

EXHIBIT E ADDITIONAL PROVISIONS

SECTION 1 – GENERAL AUTHORITY

This contract is entered into in accordance with the provisions of Part 2.5 (commencing with Section 5775) of Division 5 of the Welfare and Institutions (W&I) Code.

Part 2.5 (commencing with Section 5775) of Division 5 of the W&I Code directs the State Department of Mental Health to implement and administer Managed Mental Health Care for Medi-Cal eligible residents of this state; and _____ desires to operate the Mental Health Plan for _____ County.

SECTION 2 – DEFINITIONS

Unless otherwise expressly provided or the context otherwise requires, the following definitions of terms shall govern the construction of this contract:

- A. "Beneficiary" means any Medi-Cal beneficiary whose county of responsibility on the Medi-Cal Eligibility Data System (MEDS) or as determined pursuant to Title 9, California Code of Regulations (CCR), Section 1850.405, corresponds with the county covered by this contract.
- B. "Contractor" means _____.
- C. "Covered Services" means specialty mental health services as defined in Title 9, CCR, Section 1810.247, to the extent described in Title 9, CCR, Section 1810.345, except that psychiatric nursing facility services are not included.
- D. "Department" means the State Department of Mental Health.
- E. "DHS" means the State Department of Health Services.
- F. "Director" means the Director of the State Department of Mental Health.
- G. "HHS" means the United States Department of Health and Human Services.
- H. "Emergency Psychiatric Condition" means that a beneficiary has a condition that meets admission reimbursement criteria for medical necessity according to Title 9, CCR, Section 1820.205, and due to a mental disorder, is:
 - 1. A danger to self or others, or

2. Immediately unable to provide for or utilize food, shelter or clothing.
- I. "Facility" means any premises:
1. Owned, leased, used or operated directly or indirectly by or for the Contractor or its affiliates for purposes related to this contract, or
 2. Maintained by a provider to provide covered services on behalf of the Contractor.
- J. "Individual provider" means a provider as defined in Title 9, CCR, Section 1810.222.
- K. "Group provider" means a provider as defined in Title 9, CCR, Section 1810.218.2.
- L. "Medi-Cal managed care plan" means an entity contracting with the State Department of Health Services to provide services to enrolled beneficiaries under Chapter 7, commencing with Section 14000, or Chapter 8, commencing with Section 14200, of Division 9, Part 3 of the W&I Code.
- M. "Organizational provider" means a provider as defined in Title 9, CCR, Section 1810.231.
- N. "Post-stabilization care services" means covered services, related to an emergency medical condition, that are provided after a beneficiary is stabilized in order to maintain the stabilized condition, or, under the circumstances described in Exhibit A, Attachment 2, Section E, to improve or resolve the enrollee's condition. Post-stabilization care services include psychiatric consults in an emergency room following the initial evaluation to be post-stabilization services, if the consult does not result in a determination that the beneficiary must be admitted for emergency psychiatric inpatient hospital services. Post-stabilization services also include medically necessary acute psychiatric inpatient hospital services after the emergency psychiatric condition has been resolved.
- O. "Psychiatric nursing facility services" means services as defined in Title 9, CCR, Section 1810.239.
- P. "Public school site" means a location on the grounds of a public school at which a provider delivers specialty mental health services to beneficiaries.
- Q. "Satellite site" means a site owned, leased or operated by an organizational provider at which specialty mental health services are delivered to beneficiaries less than 20 hours per week, or, if located at a multiagency site, at which specialty mental health services are delivered by no more than two employees or contractors of the provider.

- R. "Subcontract" means an agreement entered into by the Contractor with any of the following:
1. A provider of specialty mental health services who agrees to furnish covered services to beneficiaries.
 2. Any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this contract.
- S. "Urgent condition" means a situation experienced by a beneficiary that without timely intervention is likely to result in an immediate emergency psychiatric condition.

SECTION 3 – GENERAL PROVISIONS

A. Governing Authorities

This contract shall be governed by and construed in accordance with:

Part 2.5 (commencing with Section 5775), Chapter 4, Division 5, W&I Code;

Article 5 (Sections 14680- 14685), Chapter 8.8, Division 9, W&I Code;

Title 9, CCR, Division 1, Chapter 11 (commencing with Section 1810.100);

Title 42, Code of Federal Regulations (CFR);

Title 45, CFR, Parts 160 and 164, Subparts A and E, to the extent that these requirements are applicable;

Title 42, United States Code;

Title VI of the Civil Rights Act of 1964;

Title IX of the Education Amendments of 1972;

Age Discrimination Act of 1975;

Rehabilitation Act of 1973;

Titles II and III of the Americans with Disabilities Act;

All other applicable laws and regulations; and

The terms and conditions of any Interagency Agreement between the Department of Mental Health and the State Department of Health Services related to the provision of mental health services to beneficiaries by the Contractor.

Any provision of this contract that is subsequently determined to be in conflict with the above laws, regulations, and agreements is hereby amended to conform to the provisions of those laws, regulations and agreements. Such amendment of the contract shall be effective on the effective date of the statutes, regulations or agreements necessitating it, and shall be binding on the parties hereto even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties. Such amendment shall constitute grounds for termination of this contract, in accordance with the provisions of Section 4 and Title 9, CCR, Section 1810.325(d), if the Contractor determines it is unable or unwilling to comply with the provisions of such amendment. If the Contractor gives notice of termination to the Department, the parties shall not be bound by the terms of such amendment, commencing from the time notice of termination is received by the Department until the effective date of termination.

The full text of state regulations that are cited by section number in this contract is included as Exhibit E, Attachment 1. The full text of federal regulations that are cited by section number in this contract is included as Exhibit E, Attachment 2.

SECTION 4 – TERM AND TERMINATION

A. Contract Renewal

This contract may be renewed unless good cause is shown for nonrenewal pursuant to Title 9, CCR, Section 1810.320. Renewal shall be on an annual basis.

B. Contract Termination

The Department or the Contractor may terminate this contract in accordance with Title 9, CCR, Section 1810.325.

C. Mandatory Termination

The Department shall immediately terminate this contract in the event that the Director determines that there is an immediate threat to the health and safety of beneficiaries. The department shall terminate this contract in the event that the Secretary, HHS, determines that the contract does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act. Terminations under this section shall be in accordance with Title 9, CCR, Section 1810.325.

D. Termination of Obligations

All obligations to provide covered services under this contract shall automatically terminate on the effective date of any termination of this contract. The Contractor shall be responsible for providing covered services to beneficiaries until the termination or expiration of the contract and shall remain liable for the processing and payment of invoices and statements for covered services provided to beneficiaries prior to such expiration or termination.

SECTION 5 - HIPAA BUSINESS ASSOCIATE AGREEMENT

The Contractor, referred to in this section as Business Associate, shall comply with, and assist the Department in complying with, the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), including but not limited to Title 42, United States Code, Section 1320d et seq. and its implementing regulations (including but not limited to Title 45, CFR, Parts 142, 160, 162, and 164), hereinafter collectively referred to as the "Privacy Rule." Terms used but not otherwise defined in this section shall have the same meaning as those terms are used in the Privacy Rule.

If the Department becomes aware of a pattern of activity that violates this section and reasonable steps to cure the violation are unsuccessful, the Department shall terminate the contract, or if not feasible; report the problem to the Secretary of HHS.

A. Use and Disclosure of Protected Health Information

1. Except as otherwise provided in this section, Business Associate may use or disclose protected health information (PHI) to perform functions, activities or services for or on behalf of the Department, as specified in this contract, provided that such use or disclosure would not violate the Privacy Rule if done by the Department or the minimum necessary policies and procedures of the Department.
2. Except as otherwise limited in this section, Business Associate may use and disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
3. Except as otherwise limited in this section, Business Associate may use PHI to provide data aggregation services related to the health care operation of the Department.

B. Further Disclosure of PHI

Business Associate shall not use or further disclose PHI other than as permitted or required by this section or as required by law.

C. Safeguard of PHI

Business Associate shall use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this section.

D. Unauthorized Use or Disclosure of PHI

Business Associate shall report to the Department any use or disclosure of the PHI not provided for by this section.

E. Mitigation of Disallowed Uses and Disclosures

Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by the Business Associate in violation of the requirements of this section.

F. Agents and Subcontractors of the Business Associate

Business Associate shall ensure that any agent, including a subcontractor, to which the Business Associate provides PHI received from, or created or received by the Business Associate on behalf of the Department, shall comply with the same restrictions and conditions that apply through this section to the Business Associate with respect to such information.

G. Access to PHI

Business Associate shall provide access, at the request of the Department, and in the time and manner designated by the Department, to the Department or, as directed by the Department, to PHI in a designated record set to an individual in order to meet the requirements of Title 45, CFR, Section 164.524.

H. Amendment(s) to PHI

Business Associate shall make any amendment(s) to PHI in a designated record set that the Department directs or at the request of the Department or an individual, and in the time and manner designated by the Department in accordance with Title 45, CFR, Section 164.526.

I. Documentation of Uses and Disclosures

Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for the Department to respond to a request by an individual for an accounting of disclosures of PHI in accordance with Title 45, CFR, Section 164.528.

J. Accounting of Disclosure

Business Associate shall provide to the Department or an individual, in time and manner designated by the Department, information collected in accordance with Title 45, CFR, Section 164.528, to permit the Department to respond to a request by the individual for an accounting of disclosures of PHI in accordance with Title 45, CFR, Section 164.528.

K. Records Available to the Department and Secretary of HHS

Business Associate shall make internal practices, books and records related to the use, disclosure, and privacy protection of PHI received from the Department, or created or received by the Business Associate on behalf of the Department, available to the Department or to the Secretary of HHS for purposes of the Secretary determining the Department's compliance with the Privacy Rule, in a time and manner designed by the Department or the Secretary of HHS.

L. Retention, Transfer and Destruction of Information on Contract Termination

1. Upon termination of the contract for any reason, Business Associate shall retain all PHI received from the Department, or created or received by the Business Associate on behalf of the Department in accordance with Exhibit A, Attachment 1, Section P of this contract in a manner that complies with the Privacy Rules. This provision shall apply to PHI in possession of subcontractors or agents of the Business Associate.
2. Prior to termination of the contract, the Business Associate may be required by the Department to provide copies of PHI to the Department in accordance with Exhibit A, Attachment 1, Section Q. This provision shall apply to PHI in possession of subcontractors or agents of the Business Associate.
3. When the retention requirements on termination of the contract have been met, the Business Associate shall destroy all PHI received from the Department, or created or received by the Business Associate on behalf of the Department. This provision shall apply to PHI in possession of subcontractors or agents of the Business Associate. Business Associate, its agents or subcontractors shall retain no copies of the PHI.

4. In the event that Business Associate determines that destroying the PHI is not feasible, Business Associate shall provide the Department notification of the conditions that make destruction infeasible. Upon mutual agreement of the parties that the destruction of the PHI is not feasible, Business Associate shall extend the protections of this section to such PHI and limit further use and disclosures of such PHI for so long as Business Associate, or any of its agents or subcontractors, maintains such PHI.

M. Amendments to Section

The Parties agree to take such action as is necessary to amend this section as necessary for the Department to comply with the requirements of the Privacy Rule and its implementing regulations.

N. Material Breach

If the Department becomes aware of a pattern of activity that violates this section and reasonable steps to cure the violation are unsuccessful, the Department shall terminate the contract, or if not feasible; report the problem to the Secretary of HHS.

O. Survival

The respective rights and obligations of Business Associate shall survive the termination of this contract.

P Interpretation

Any ambiguity in this section shall be resolved to permit the Department to comply with the Privacy Rule.

SECTION 6– DUTIES OF THE STATE

In discharging its obligations under this contract, the State shall perform the following duties:

A. Payment for Services

Pay the appropriate payments set forth in Exhibit B.

B. Reviews

Conduct reviews of access and quality of care at least once every three years and issue reports to the Contractor detailing findings, recommendations, and corrective

action, as appropriate, under Title 9, CCR, Sections 1810.380 and 1810.385. Arrange for an annual external quality review of the Contractor as required by Title 42, CFR, Section 438,204(d).

C. Monitoring for Compliance

Monitor the operation of the Contractor for compliance with the provisions of this contract, and applicable federal and state law and regulations. Such monitoring activities will include, but not be limited to, inspection and auditing of Contractor facilities, management systems and procedures, and books and records as the Department deems appropriate, at any time during the Contractor's or facility's normal business hours. When monitoring activities identify areas of non-compliance, issue reports to the Contractor detailing findings, recommendations, and corrective action, as appropriate, under Title 9, CCR, Sections 1810.380 and 1810.385.

D. Approval Process

1. In the event that the Contractor requests changes to its Implementation Plan, the Department shall provide a Notice of Approval or Notice of Disapproval including the reasons for the disapproval, to the Contractor within 30 calendar days after the receipt of the request from the Contractor. The Contractor may implement the proposed changes 30 calendar days from submission to the Department, if the Department fails to provide a Notice of Approval or Disapproval.
2. The Department shall act promptly to review the Contractor's Cultural Competence Plan submitted pursuant to Exhibit A, Attachment 1, Item K. The Department shall provide a Notice of Approval or a Notice of Disapproval including the reasons for the disapproval, to the Contractor within 60 calendar days after the receipt of the plan from the Contractor. The Contractor may implement the plan 60 calendar days from submission to the Department if the Department fails to provide a Notice of Approval or Disapproval.
3. The Department shall act promptly to review requests from the Contractor for approval of subcontracts with providers that meet the conditions described in Title 9, CCR, Section 1810.438. The Department shall act to approve or disapprove the reimbursement and related claiming and cost reporting issues included in the subcontract within 60 days of receipt of a request from the Contractor. If the Department disapproves the request, the Department shall provide the Contractor with the reasons for disapproval.

E. Certification of Organizational Provider Sites Owned or Operated by the Contractor

The Department shall certify the organizational provider sites that are owned, leased or operated by the Contractor, in accordance with Title 9, CCR, Section 1810.435 and the requirements specified in Exhibit A, Attachment 1, Appendix D. This

certification shall be prior to the date on which the Contractor begins to deliver services under this contract at these sites and once every three years after that date, unless the Department determines an earlier date is necessary. The on-site review required by Title 9, CCR, Section 1810.435(e), shall be made of any site owned, leased, or operated by the Contractor and used for to deliver covered services to beneficiaries, except that on-site review is not required for public school or satellite sites.

The Department may allow the Contractor to begin delivering covered services to beneficiaries at a site subject to on-site review by the Department prior to the date of the on-site review, provided the site is operational and has any required fire clearances. The earliest date the Contractor may begin delivering covered services at a site subject to on site review by the Department is latest of the date the Contractor requested certification of the site in accordance with procedures established by the Department, the date the site was operational, or the date a required fire clearance was obtained.

The Department may allow the Contractor to continue delivering covered services to beneficiaries at a site subject to on-site review by the Department as part of the recertification process prior to the date of the on-site review, provided the site is operational and has any required fire clearances.

Nothing in this section precludes the Department from establishing procedures for issuance of separate provider identification numbers for each of the organizational provider sites operated by the Contractor to facilitate the claiming of federal financial participation by the Contractor and the Department's tracking of that information.

F. Development and Distribution of Informing Materials

- a. Annually review the Contractor's beneficiary brochure and provider list for changes in federal and state laws and rules and changes to Contractor-specific information. If changes are required, develop the revised brochure and provider list and provide to the Contractor. The beneficiary brochure and provider list shall include the information required by Title 42, CFR, Section 438.10(f) and (g), including information specific to Contractor provided pursuant to Exhibit A, Attachment 1, Section V. The informing materials shall meet the language and format standards required by Title 42, CFR, Section 438.10(c) and (d).
 - 1) In addition to any requirements of Title 42, CFR, Section 438.10(f) and (g), the beneficiary brochure shall advise beneficiaries of the availability on request of a listing of cultural/linguistic services available through the Contractor.
 - 2) In addition to any requirements of Title 42, CFR, Section 438.10(f) and (g), the provider list shall include information on the category or categories of services available from each provider. At a minimum the services available from the

provider shall be categorized as psychiatric inpatient hospital services, targeted case management services and/or all other specialty mental health services. At the election of the Contractor, the list may include instructions to the beneficiary explaining how appointments may be scheduled and information on cultural and/or linguistic services available from the providers.

- b. On a one-time basis, distribute a beneficiary brochure and provider list to all beneficiary households and all current clients as an initial distribution, including provider lists only in the distribution to current clients.
- c. Distribute the most current beneficiary brochure developed pursuant to paragraph a. to new beneficiaries on an ongoing basis.
- d. Pursuant to Title 42, CFR, Section 438.10(f)(4), when there is a change in covered services under the contract, develop and distribute an update in the form of a beneficiary brochure insert and distribute to all Medi-Cal households and to the Contractor for inclusion in informing materials provided to new clients at least 30 days prior to the change. The Department shall work with the California Mental Health Directors Association to determine if notices of changes during the year outside the annual update process, in addition to notices related to changes in covered services under the contract, should be provided to beneficiaries.
- e. Provide annual notice to all beneficiaries in accordance with Title 42, CFR, Section 438.10(f)(2).

G. Sanctions

Apply oversight and sanctions in accordance with Title 9, CCR, Sections 1810.380 and 1810.385, to the Contractor for violations of the terms of this contract, and applicable federal and state law and regulations.

H. Notification

Notify beneficiaries of their Medi-Cal specialty mental health benefits and options available upon termination or expiration of this contract.

I. Performance Measurement

Measure the Contractor's performance based on Medi-Cal approved claims and other data available to the Department using standard measures established by the Department in consultation with the State Quality Improvement Council.

J. Data Certification

Require that the Contractor certify data provided by the Contractor that will be used by the State to determine payment rates to the Contractor in accordance with Title 42, CFR, Section 438.604 and 438.606.

SECTION 7 – SUBCONTRACTS

- A. No subcontract terminates the legal responsibility of the Contractor to the Department to assure that all activities under the contract are carried out.
- B. All subcontracts must be in writing.
- C. All inpatient subcontracts must require that subcontractors maintain necessary licensing and certification.
- D. Each subcontract must contain:
 - a. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from the Contractor.
 - b. Specification of the services to be provided.
 - c. Specification that the subcontract shall be governed by and construed in accordance with all laws, regulations, and contractual obligations of the Contractor under this contract.
 - d. Specification of the term of the subcontract including the beginning and ending dates as well as methods for amendment, termination and, if applicable, extension of the subcontract.
 - e. The nondiscrimination and compliance provisions of this contract as described in Exhibit D, Section 7.
 - f. Subcontractor's agreement to submit reports as required by the Contractor.
 - g. The subcontractor's agreement to make all of its books and records, pertaining to the goods and services furnished under the terms of the subcontract, available for inspection, examination or copying by the Department, DHS, HHS, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized representatives, at all reasonable times at the subcontractor's place of business or at such other mutually agreeable location in California, in a form maintained in accordance with the general standards applicable to such book or record keeping, for a term of at least five years from the close of the Department's fiscal year in which the subcontract was in effect.

- h. Subcontractor's agreement that assignment or delegation of the subcontract shall be void unless prior written approval is obtained from the Contractor.
- i. Subcontractor's agreement to hold harmless both the State and beneficiaries in the event the Contractor cannot or shall not pay for services performed by the subcontractor pursuant to the subcontract.
- j. If applicable based on the services provided under the subcontract, the subcontractor's agreement to comply with the Contractor's policies and procedures on advance directives pursuant to Exhibit A, Attachment 3, Section A, and the Contractor's obligations for Physician Incentive Plans pursuant to Exhibit A, Attachment 3, Section B.

STATE REGULATIONS CROSS-REFERENCED IN CONTRACT

TITLE 9. CALIFORNIA CODE OF REGULATIONS

Chapter 11. Medi-Cal Specialty Mental Health Services

Subchapter 1. General Provisions

Article 2. Definitions, Abbreviations and Program Terms

1810.212. Day Rehabilitation.

“Day Rehabilitation” means a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of beneficiaries and is available at least three hours and less than twenty-four hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.213. Day Treatment Intensive.

“Day Treatment Intensive” means a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting, with services available at least three hours and less than twenty-four hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.215. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Specialty Mental Health Services.

“EPSDT supplemental specialty mental health services” means those services defined in Title 22, Section 51184, that are provided to correct or ameliorate the diagnoses listed in Section 1830.205, and that are not otherwise covered by this chapter.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14132, and 14684, Welfare and Institutions Code, and Title 42, Section 1396d(r), United States Code.

1810.216. Emergency Psychiatric Condition.

"Emergency Psychiatric Condition" means a condition that meets the criteria in Section 1820.205 when the beneficiary with the condition, due to a mental disorder, is a danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing, and requires psychiatric inpatient hospital or psychiatric health facility services.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 14684, Welfare and Institutions Code.

1810.216.1. Fair Hearing.

"Fair Hearing" means the State hearing provided to beneficiaries pursuant to Title 22, Sections 50951 and 50953.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 10950-10965 and 14684, Welfare and Institutions Code.

1810.218.2. Group Provider.

"Group Provider" means an organization that provides specialty mental health services through two or more individual providers. Group providers include entities such as independent practice associations, hospital outpatient departments, health care service plans, and clinics.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 14684, Welfare and Institutions Code.

1810.222. Individual Provider.

"Individual Provider" means licensed mental health professionals whose scope of practice permits the practice of psychotherapy without supervision who provide specialty mental health services directly to beneficiaries. Individual provider includes licensed physicians, licensed psychologists, licensed clinical social workers, licensed marriage, family and child counselors, and registered nurses with a master's degree within their scope of practice. Individual provider does not include licensed mental health professionals when they are acting as employees of any organizational provider or contractors of organizational providers other than the MHP.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 14684, Welfare and Institutions Code.

1810.223. Licensed Mental Health Professional.

"Licensed mental health professional" means licensed physicians, licensed clinical psychologists, licensed clinical social workers, licensed marriage, family and child counselors, registered nurses, licensed vocational nurses, and licensed psychiatric technicians.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1810.226. Mental Health Plan (MHP).

"Mental Health Plan" (MHP) means an entity which enters into an agreement with the department to arrange for and/or provide specialty mental health services to beneficiaries in a county as provided in this chapter. An MHP may be a county, counties acting jointly or another governmental or nongovernmental entity.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5775, 5777, 5778, and 14684, Welfare and Institutions Code.

1810.227. Mental Health Services.

"Mental Health Services" means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.229. MHP Payment Authorization.

"MHP Payment Authorization" means the written, electronic or verbal authorization given by an MHP to a provider for reimbursement of specialty mental health services provided to a beneficiary. In addition to obtaining any required MHP payment authorization, the provider must meet all other applicable Medi-Cal requirements and requirements of the contract between the MHP and the provider to ensure reimbursement by the MHP.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1810.231. Organizational Provider.

"Organizational provider" means a provider of specialty mental health services other than psychiatric inpatient hospital services or psychiatric nursing facility services that provides the services to beneficiaries through employed or contracting licensed mental health or waived/registered professionals and other staff. The MHP is an organizational provider when specialty mental health services are provided to beneficiaries by employees of the MHP.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 14684, Welfare and Institutions Code.

1810.237.1. Psychiatric Inpatient Hospital Professional Services.

“Psychiatric Inpatient Hospital Professional Services” means specialty mental health services provided to a beneficiary by a licensed mental health professional with hospital admitting privileges while the beneficiary is in a psychiatric inpatient hospital. Psychiatric inpatient hospital professional services do not include all specialty mental health services that may be provided in an inpatient setting. Psychiatric inpatient hospital professional services include only those services provided for the purpose of evaluating and managing the mental disorder that resulted in the need for psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include routine hospital services or hospital-based ancillary services.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 14684, Welfare and Institutions Code.

1810.239. Psychiatric Nursing Facility Services.

“Psychiatric Nursing Facility Services” means skilled nursing facility services as defined in Title 22, Section 51123, that include special treatment program services for mentally disordered persons as defined in Chapter 3, Division 5, Title 22, provided by an entity that is licensed as a skilled nursing facility by the State Department of Health Services and is certified by the department to provide special treatment program services.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14132, and 14684, Welfare and Institutions Code.

1810.247. Specialty Mental Health Services.

“Specialty Mental Health Services” means:

(a) Rehabilitative Services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.

(b) Psychiatric Inpatient Hospital Services;

(c) Targeted Case Management;

(d) Psychiatrist Services;

(e) Psychologist Services;

(f) EPSDT Supplemental Specialty Mental Health Services; and

(g) Psychiatric Nursing Facility Services.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14021.3, 14021.4, 14132, and 14684, Welfare and Institutions Code.

1810.253. Urgent Condition.

“Urgent Condition” means a situation experienced by a beneficiary that, without timely intervention, is certain to result in an immediate emergency psychiatric condition.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777 and 14684, Welfare and Institutions Code.

1810.254. Waivered/Registered Professional.

“Waivered/Registered Professional” means an individual who has a waiver of psychologist licensure issued by the department or has registered with the applicable state licensing authority to obtain supervised clinical hours for Marriage, Family and Child Counselor or Clinical Social Worker licensure.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777 and 14684, Welfare and Institutions Code.

Article 3. Administration

1810.310. Implementation Plan.

(a) An entity designated as an MHP shall submit an Implementation Plan to the department, within the time frame established by the department. The time frame shall be no more than 180 days and no less than 90 calendar days prior to the date on which the entity proposes to begin operations. The Implementation Plan shall include:

(1) Procedures for MHP payment authorization of specialty mental health services by the MHP, including a description of the point of authorization.

(2) A description of the process for:

(A) Screening, referral and coordination with other necessary services, including, but not limited to, substance abuse, educational, health, housing and vocational rehabilitation services.

(B) Outreach efforts for the purpose of providing information regarding access under the MHP to beneficiaries and providers.

(C) Assuring continuity of care for beneficiaries receiving specialty mental health services prior to the date the entity begins operation as the MHP.

(D) Providing clinical consultation and training to beneficiaries' primary care physicians and other physical health care providers.

(3) A description of the processes for problem resolution as required in Subchapter 6.

(4) A description of the provider selection process, including provider selection criteria consistent with Sections 1810.425 and 1810.435. The MHP shall include a Request for Exemption from Contracting in accordance with Section 1810.430(c) if the MHP decides not to contract with a Traditional Hospital or DSH.

(5) A description of the provision, to the extent feasible, of age-appropriate services to beneficiaries.

(6) The MHP's proposed Cultural Competence Plan as described in Section 1810.410, unless the department has determined that the Cultural Competence Plan will be submitted in accordance with the terms of the contract between the MHP and the department pursuant to Section 1810.410(c).

(7) A description of a process for planned admissions in non-contract hospitals if such an admission is determined to be necessary by the MHP.

(8) A description of the MHP's Quality Improvement and Utilization Management Programs.

(9) A description of policies and procedures that assure beneficiary confidentiality in compliance with applicable state and federal laws and regulations.

(10) Other policies and procedures identified by the department as relevant to determining readiness to provide specialty mental health services to beneficiaries as described in this chapter.

(b) The department shall review and either approve, disapprove, or request additional information for each Implementation Plan. Notices of Approval, Notices of Disapproval and requests for additional information shall be forwarded to applicant MHP entities within 60 calendar days of the receipt of the Implementation Plan.

(c) Prior to implementing changes in the policies, processes or procedures that modify its current Implementation Plan, an MHP shall submit its proposed changes in writing to the department for review. If the changes are consistent with this chapter, the changes shall be approved by the department. The department shall provide a Notice of Approval or a Notice of Disapproval, including the reasons for disapproval, to the MHP within 30 calendar days after the receipt of the notice from the MHP. The MHP may implement the proposed changes 30 calendar days from submission to the department if the department fails to provide a Notice of Approval or Disapproval.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5775, 5777, 5778, 14683, and 14684, Welfare and Institutions Code.

1810.320. Contract Renewal.

(a) A MHP contract shall be renewed unless good cause is shown for nonrenewal. The term of a renewed contract shall be one year. Good cause for nonrenewal shall include, but not be limited to the following:

(1) Failure of the MHP to comply with all terms and conditions of the contract and with all applicable laws and regulations.

(2) The department's finding of fact, based upon the MHP's past performance under its contract, that it does not have the ability to fulfill the terms of the contract with the State.

(b) The department shall have final discretionary authority in the renewal of the MHP contract.

(c) If either party chooses nonrenewal of the contract, then the MHP or the department must give to the other party at least 180 calendar days prior notice of nonrenewal.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5775, 5777, and 5778, Welfare and Institutions Code.

1810.325. Contract Termination.

(a) The MHP may terminate its contract with the department in accordance with the terms of its contract with the department by delivering written notice of termination to the department at least 180 calendar days prior to the effective date of termination.

(b) The department shall immediately terminate its contract with an MHP if the department finds that there is an immediate threat to the health and safety of Medi-Cal beneficiaries.

(c) The department shall terminate its contract with an MHP that the Secretary, Health and Human Services has determined does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act. The department shall deliver written notice of termination to the MHP at least 60 calendar days prior to the proposed effective date of termination.

(d) The department may terminate the MHP contract for noncompliance with the requirements of law or regulations or terms of the contract. The department shall deliver written notice of termination to the MHP at least 90 calendar days prior to the proposed effective date of termination.

(e) The department may terminate its contract with an MHP for any reason not specified in subsections (b), (c), or (d) by delivering written notice of termination to the MHP at least 180 calendar days prior to the proposed effective date of termination.

(f) The written notice of termination shall be provided to the MHP and to other persons and organizations as the department may deem necessary.

(g) The written notice of termination shall include the reason for the termination and the proposed effective date of termination.

(h) The MHP may appeal, in writing, a proposed contract termination to the department within 15 working days after the date of receipt of the notice of termination, setting forth relevant facts and arguments. The department shall grant or deny the appeal within 30 calendar days after receipt of the appeal. In granting an appeal, the department may take another action available under Section 1810.380(b). The department's election to take another action shall not be appealable to the department. Except for terminations pursuant to subsection (c), the department shall pend the termination date until the department has acted on the MHP's appeal.

(1) The MHP may request that a public hearing be held by the Office of Administrative Hearings to allow the department to show cause for the termination. The public hearing shall be held no later than 30 calendar days after receipt by the MHP of the notice to terminate the contract. In order to give the Office of Administrative Hearings sufficient time to arrange for a hearing, the MHP request for a hearing shall be submitted no later than five working days after receipt of the notice to terminate, by making its request to the Office of Administrative Hearings directly.

(2) The Office of Administrative Hearings shall provide written recommendations concerning the termination of the contract to the department and to the MHP within 30 calendar days after conclusion of the hearing. The department shall act to grant or deny the appeal within 30 calendar days after receipt of the recommendations of the Office of Administrative Hearings. In granting an appeal, the department may take another action available under Section 1810.380(b). The department's election to take another action shall not be appealable to the department or to the Office of Administrative Hearings. Except for terminations pursuant to subsection (c), the department shall pend the termination date until the department has acted on the MHP's appeal.

(i) In the event that the contract with an MHP is terminated for any cause, the remaining balance of State funds which were transferred to the MHP for specialty mental health services shall be returned to the department on a timeline specified by the department in the notice of termination. The State has a right to examine all records of an MHP to determine the balance of funds to be returned to the department.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5775, 5776, 5777, 5778, and 5780, Welfare and Institutions Code.

1810.330. Allocation of State Funds to MHPs.

In consultation with a statewide organization representing counties, the department shall determine the methodology for allocating state funds to the MHPs annually. The methodology shall include a determination of the appropriate level for the Small County Reserve allocation. The allocation shall include state funds for specialty mental health services covered by the MHP that are not eligible for federal financial participation pursuant to Subchapter 4, subject to the appropriation of such funds by the legislature. State funds based on the allocation process shall be provided to each MHP annually in accordance with the terms of its contract with the department and to the Small County Reserve, if applicable.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 5778, Welfare and Institutions Code.

1810.345. Scope of Covered Specialty Mental Health Services.

(a) The MHP of a beneficiary shall provide or arrange and pay for specialty mental health services to the beneficiary when the medical necessity criteria in Sections 1820.205, 1830.205, or 1830.210 are met and when specialty mental health services are required to assess whether the medical necessity criteria are met. Except as provided elsewhere in this chapter, the MHP shall not be required to provide or arrange for any specific specialty mental health service, but shall ensure that the specialty mental health services available are adequate to meet the needs of the beneficiary as described in the medical necessity criteria in Sections 1820.205, 1830.205, or 1830.210 as applicable. The MHP of a beneficiary shall be required to provide specialty mental health services only to the extent the beneficiary is eligible for those services based on the beneficiary's Medi-Cal eligibility under Title 22, Division 3, Subdivision 1, Chapter 2, Article 5 and Article 7.

(b) The department may exclude psychiatric nursing facility services from the specialty mental health services covered by the MHP until the department determines that all necessary systems are in place at the State level to ensure proper payment of the providers of psychiatric nursing facility services and proper claiming of federal funds pursuant to Subchapter 4. The department shall adjust the contract between the MHP and the department and the allocation to the MHP pursuant to Section 1810.330 to reflect the exclusion and inclusion of these services as appropriate.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5775, 5777, 14007.5, 14011, 14142, 14145, 14682, Welfare and Institutions Code.

1810.350. Scope of Covered Psychiatric Inpatient Hospital Services.

(a) An MHP shall be responsible for the MHP payment authorization for psychiatric inpatient hospital services as described in Section 1810.345 and in (b) and (c).

(b) Psychiatric Inpatient Hospital Services for a Fee-for-Service/Medi-Cal hospital shall include:

- (1) Routine hospital services and
- (2) All hospital-based ancillary services.
- (c) Psychiatric Inpatient Hospital Services for a Short-Doyle/Medi-Cal hospital shall include:

- (1) Routine hospital services,
- (2) All hospital-based ancillary services, and
- (3) Psychiatric inpatient hospital professional services.

(d) An MHP shall be responsible for the MHP payment authorization for psychiatric inpatient hospital services provided to a beneficiary eligible for Medicare (Part A) if the payment being authorized is for administrative day services following any approved acute psychiatric inpatient hospital services day and there is compliance with Section 1820.220(j)(5).

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1810.360. Notification of Beneficiaries.

(a) Prior to the date the MHP begins operations, the department shall mail a notice to all beneficiaries in a county containing the following information:

- (1) The date the MHP will begin operation.
- (2) The name and statewide, toll-free telephone number of the MHP.
- (3) The availability of a brochure and provider list from the MHP upon request.

(b) The department shall ensure that the notice described in subsection (a) is provided to new beneficiaries either through the mail, through the Medi-Cal eligibility determination process, or through other appropriate means.

(c) The MHP of the beneficiary shall provide beneficiaries with a brochure upon request or when a beneficiary first accesses services. The beneficiary brochure shall contain the following information:

- (1) A description of the services available.
- (2) A description of the process for obtaining services, including the MHP's statewide toll-free telephone number.

(3) A description of the MHP's beneficiary problem resolution process, including the complaint resolution and grievance processes and the availability of fair hearings.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Section 14683, Welfare and Institutions Code.

1810.365. Beneficiary Billing.

(a) The MHP of a beneficiary, or an affiliate, vendor, contractor, or sub-subcontractor of the MHP shall not submit a claim to, demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this chapter except to collect:

(1) Other health care coverage pursuant to Title 22, Section 51005.

(2) Share of cost as provided in Title 22, Sections 50657 through 50659.

(3) Copayments in accordance with Welfare and Institutions Code, Section 14134, and Title 22, Section 51004.

(b) In the event that a beneficiary willfully refuses to provide other current health insurance coverage billing information as described in Title 22, Section 50763(a)(5) to a provider, including the MHP, upon giving the beneficiary written notice of intent, the provider may bill the beneficiary as a private pay patient.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14005.9, 14024, and 14134, Welfare and Institutions Code.

1810.370. MOUs with Medi-Cal Managed Care Plans.

(a) The MHP shall enter into an MOU with any Medi-Cal Managed Care Plan that enrolls beneficiaries covered by the MHP. The MOU shall, at a minimum, address the following:

(1) Referral protocols between plans, including how the MHP will provide a referral to the Medi-Cal managed care plan when the MHP determines that the beneficiary's mental illness would be responsive to physical health care based treatment and how the Medi-Cal managed care plan will provide a referral when the Medi-Cal managed care plan determines specialty mental health services covered by the MHP may be required.

(2) The availability of clinical consultation, including consultation on medications, to the Medi-Cal managed care plan for beneficiaries whose mental illness is being treated by the Medi-Cal managed care plan.

(3) Appropriate management of a beneficiary's care, including procedures for the exchange of medical records information, which maintain confidentiality in accordance with applicable state and

federal laws and regulations. The procedures shall ensure that the confidentiality of medical records is maintained in accordance with applicable state and federal laws and regulations.

(4) Procedures for providing beneficiaries with services necessary to the treatment of mental illnesses covered by the MHP when those necessary services are covered by the Medi-Cal managed care plan. The procedures shall address, but are not limited to:

(A) Prescription drugs and laboratory services covered by the Medi-Cal managed care plan and prescribed through the MHP. Prescription drug and laboratory service procedures shall include:

1. The MHP's obligation to provide the names and qualifications of the MHP's prescribing physicians to the Medi-Cal managed care plan, if the Medi-Cal managed care plan covers prescription drugs.

2. The Medi-Cal managed care plan's obligation to provide the Medi-Cal managed care plan's procedures for obtaining authorization of prescribed drugs and laboratory services and a list of available pharmacies and laboratories to the MHP, if the Medi-Cal managed care plan covers these services.

(B) Emergency room facility and related services other than specialty mental health services, home health services, non-emergency medical transportation, and services to treat the physical health care needs of beneficiaries who are inpatients in a psychiatric inpatient hospital, including the history and physical required upon admission.

(C) Direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address a beneficiary's medical problems based on changes in the beneficiary's mental health or medical condition.

(5) A process for resolving disputes between the MHP and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services, including specialty mental health services and prescription drugs, while the dispute is being resolved.

(b) If the MHP does not enter into an MOU with the Medi-Cal managed care plan, the MHP shall not be out of compliance with this section provided the MHP establishes to the satisfaction of the department that it has made good faith efforts to enter into an MOU.

(c) When enrollment in a Medi-Cal managed care plan in any county is 2000 beneficiaries or less, the department shall, at the request of the MHP or the Medi-Cal managed care plan, grant a waiver from the requirements of this section provided both plans provide assurance that beneficiary care will be coordinated in compliance with Section 1810.415.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Section 14681, Welfare and Institutions Code.

1810.380. State Oversight.

(a) The department shall provide ongoing oversight to an MHP through site visits and monitoring of data reports from MHPs and claims processing. In addition, the department shall:

(1) Perform reviews of program and fiscal operations of each MHP to verify that medically necessary services are provided in compliance with this chapter and the provisions of the approved federal waiver for Medi-Cal Specialty Mental Health Services Consolidation.

(2) Perform immediate on-site reviews of MHP program operations whenever the department obtains information indicating that there is a threat to the health or safety of beneficiaries.

(3) Monitor compliance with problem resolution process requirements contained in Subchapter 5 and the MHP's Implementation Plan.

(4) Monitor provider contracts to ensure that the MHP enters into necessary contracts with DSH and Traditional Hospitals.

(5) Monitor denials of MHP payment authorizations.

(b) If the department determines that an MHP is out of compliance with State or Federal laws and regulations, the department may take any or all of the following actions:

(1) Require that the MHP develop a plan of correction.

(2) Withhold all or a portion of payments due to the MHP from the department.

(3) Impose civil penalties pursuant to Section 1810.385.

(4) Require that the MHP meet reporting, access to care, quality of care, provider reimbursement, and beneficiary and provider problem resolution process requirements that exceed the requirements of this chapter.

(5) Terminate the contract with the MHP pursuant to Section 1810.325.

(6) Take other actions deemed necessary to encourage and ensure contract and regulatory compliance.

(c) If the department determines that an action should be taken pursuant to subsection (b), the department shall provide the MHP with a written Notice of Noncompliance. The Notice of Noncompliance shall include:

(1) A description of the violation.

(2) A description of any corrective action required by the department and time limits for compliance.

(3) A description of any and all proposed actions by the department under this section, Section 1810.385, or Section 1810.325 and any related appeal rights.

(d) Except as provided in Section 1810.325, the MHP may appeal the Notice of Noncompliance to the department, in writing, within 15 working days after the receipt of the notice, setting forth relevant facts and arguments. The department shall grant or deny the appeal in whole or in part within 30 calendar days after receipt of the appeal. The department shall pend any proposed action pursuant to subsection (c)(3) until the department has acted on the MHP's appeal.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1810.385. Civil Penalties.

(a) The department may impose one or more of the civil penalties specified in (b) upon an MHP which fails to comply with the provisions of Part 2.5, Division 5, and Articles 4 and 5, Chapter 8.8, Part 3, Division 9, Welfare and Institutions Code, the provisions of this chapter, or the terms of the MHP's contract with the department.

(b) Civil penalties imposed by the department shall be in the amounts specified below with respect to violation of:

(1) The provisions of Section 1810.350, "Notification of Beneficiaries", Section 1850.205, "Beneficiary Problem Resolution Processes", Section 1850.210, "Fair Hearing and Notice of Action", and Section 1850.215, "Medical Assistance for Beneficiary Pending Fair Hearing Decision".

(A) First violation: \$1,000.

(B) Second and each subsequent violation: \$5,000.

(2) The provisions of Section 1810.375, "MHP Reporting", and any other regulation or contract provision establishing a time frame for action.

(A) First violation: \$500, plus \$25 per day for each day that the item to be submitted is late.

(B) Second and each subsequent violation: \$500, plus \$25 per day for each day that the item to be submitted is late.

(3) Any provision of this chapter which is not specifically addressed in this section.

(A) First violation: \$500.

(B) Second violation: \$1,000.

(C) Third and each subsequent violation: \$5,000.

(4) Any provision of the contract between the MHP and the department which is not specifically governed by regulation in this chapter.

(A) First violation: \$500.

(B) Second and subsequent violations: \$1,000.

(5) Any provision of Part 2.5, Division 5, and Articles 4 and 5, Chapter 8.8, Part 3, Division 9, Welfare and Institutions Code, which is not specifically addressed by regulations in this chapter.

(A) First violation: \$1,000.

(B) Second and subsequent violations: \$1,000.

(c) When the department issues a notice of noncompliance as described in Section 1810.380 to an MHP found by the department to be in violation of any provision of law, regulation or the contract, failure to comply with corrective actions in the notice within the time limits given shall be deemed to be a subsequent violation under this section.

NOTE: Authority: Sections 5775(e)(1) and 14680, Welfare and Institutions Code.

Reference: Sections 5775(e)(1) and 5777, Welfare and Institutions Code.

Article 4. Standards

1810.405. Access Standards for Specialty Mental Health Services.

(a) The MHP of the beneficiary shall be responsible for assuring that the beneficiary has access to specialty mental health services as provided in Section 1810.345 and Section 1810.350.

(b) Referrals to the MHP for Specialty Mental Health Services may be received through beneficiary self referral or through referral by another person or organization, including but not limited to:

(1) Physical health care providers

(2) Schools

- (3) County welfare departments
- (4) Other MHPs.
- (5) Conservators, guardians, or family members.
- (6) Law enforcement agencies.

(c) Each MHP shall make specialty mental health services to treat a beneficiary's urgent condition available 24 hours a day, seven days per week. If the MHP requires that a provider obtain approval of an MHP payment authorization request prior to the delivery of a specialty mental health service to treat a beneficiary's urgent condition as a condition of payment to the provider, the MHP shall have a statewide, toll-free telephone number available 24 hours a day, seven days per week, to act on MHP payment authorization requests for specialty mental health services to treat a beneficiary's urgent condition. Under these circumstances, the MHP shall act on the MHP payment authorization request within one hour of the request.

(d) Each MHP shall provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in the languages spoken by beneficiaries of the county, that will provide information to beneficiaries about how to access specialty mental health services, including services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes.

(e) At the request of a beneficiary, the MHP of the beneficiary shall provide for a second opinion by a licensed mental health professional employed by, contracting with or otherwise made available by the MHP when the MHP or its providers determine that the medical necessity criteria in Section 1830.205(b)(1), (b)(2) or (b)(3)(C) or Section 1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the MHP. The MHP shall determine whether the second opinion requires a face-to-face encounter with the beneficiary.

(f) The MHP shall maintain a written log of the initial requests for specialty mental health services from beneficiaries of the MHP. The requests shall be recorded whether they are made via telephone, in writing, or in person. The log shall contain the name of the beneficiary, the date of the request, and the initial disposition of the request.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Section 5778, Welfare and Institutions Code.

1810.410 Cultural and Linguistic Requirements.

(a) Each MHP shall comply with the cultural competence and linguistic requirements included in this section, the terms of the contract between the MHP and the department, and the MHP's Cultural Competence Plan established pursuant to subsection (b). The terms of the contract between the MHP and the department may provide additional requirements for the

Cultural Competence Plan, including a description of the acceptable data sources and requirements for arraying data for the components of the Cultural Competence Plan.

(b) Each MHP shall develop and implement a Cultural Competence Plan which includes the following components:

(1) Objectives and strategies for improving the MHP's cultural competence based on the assessments required in subsections (b)(2) and the MHP's performance on the standards in subsections (d).

(2) A population assessment and an organizational and service provider assessment focusing on issues of cultural competence and linguistic capability.

(3) A listing of specialty mental health services and other MHP services available for beneficiaries in their primary language by location of the services.

(4) A plan for cultural competency training for the administrative and management staff of the MHP, the persons providing specialty mental health services employed by or contracting with the MHP or with contractors of the MHP, and the persons employed by or contracting with the MHP or with contractors of the MHP to provide interpreter or other support services to beneficiaries.

(c) The department shall establish timelines for the submission and review of the Cultural Competence Plan described in subsection (b) either as a component of the Implementation Plan process described in Section 1810.310 or as a term of the contract between the MHP and the department. The MHP shall submit the Cultural Competence Plan to the department for review and approval in accordance with these timelines. The MHP shall update the Cultural Competence Plan and submit these updates to the department for review and approval annually.

(d) Each MHP shall provide:

(1) A statewide, toll-free telephone number available 24 hours a day, seven days a week, with language capability in all the languages spoken by the beneficiaries of the MHP as required by Section 1810.405(d).

(2) Interpreter services in threshold languages at key points of contact available to assist beneficiaries whose primary language is a threshold language to access the specialty mental health services or related services available through that key point of contact. The threshold languages shall be determined on a countywide basis. MHPs may limit the key points of contact at which interpreter services in a threshold language are available to a specific geographic area within the county when:

(A) The MHP has determined, for a language that is a threshold language on a countywide basis, that there are geographic areas of the county where that language is a threshold language, and other areas where it is not; and

(B) The MHP provides referrals for beneficiaries who prefer to receive services in that threshold language, but who initially access services outside the applicable area, to a key point of contact that does have interpreter services in that threshold language.

(3) General program literature used by the MHP to assist beneficiaries in accessing services including, but not limited to, the beneficiary brochure required by Section 1810.360(c), materials explaining the beneficiary problem resolution and fair hearing processes required by Section 1850.205(c)(1), and health education materials used by the MHP, in threshold languages, based on the threshold languages in the county as a whole.

(e) In consultation with representatives from MHPs, beneficiaries, and community-based diverse cultural and linguistic groups, the department shall develop, and update as appropriate, a set of comprehensive cultural and linguistic requirements which may be incorporated into regulation as changes to Cultural Competence Plan requirements or as specific standards or into the contract between the department and each MHP.

(f) Definitions:

(1) "Key points of contact" means common points of access to specialty mental health services from the MHP, including the MHP's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the MHP.

(2) "Primary language" means that language, including sign language, which must be used by the beneficiary to communicate effectively and which is so identified by the beneficiary.

(3) "Threshold Language" means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Section 5777, 5778, 14684, Welfare and Institutions Code.

1810.435. MHP Individual, Group and Organizational Provider Selection Criteria.

(a) Each MHP shall establish individual, group, and organizational provider selection criteria that comply with the requirements of this section, the terms of the contract between the MHP and the department, and the MHP's Implementation Plan pursuant to Section 1810.310.

(b) In selecting individual or group providers with which to contract, the MHP shall require that each individual or group provider:

(1) Possess the necessary license or certification to practice psychotherapy independently. Each individual practicing as part of a group provider shall possess the necessary license or certification.

(2) Maintain a safe facility.

(3) Store and dispense medications in compliance with all applicable state and federal laws and regulations.

(4) Maintain client records in a manner that meets state and federal standards.

(5) Meet the MHP's Quality Management Program standards.

(6) Meet any additional requirements established by the MHP as part of a credentialing or other evaluation process.

(c) In selecting organizational providers with which to contract, the MHP shall require that each provider:

(1) Possess the necessary license to operate.

(2) Provide for appropriate supervision of staff.

(3) Have as head of service a licensed mental health professional or other appropriate individual as described in Sections 622 through 630.

(4) Possess appropriate liability insurance.

(5) Maintain a safe facility.

(6) Store and dispense medications in compliance with all pertinent state and federal standards.

(7) Maintain client records in a manner that meets state and federal standards.

(8) Meet the MHP's Quality Management Program standards and requirements.

(9) Have accounting and fiscal practices that are sufficient to comply with its obligations pursuant to Section 1840.105.

(10) Meet any additional requirements established by the MHP as part of a credentialing or other evaluation process.

(d) The MHP shall certify that a provider other than the MHP meets the applicable criteria in subsections (b) or (c) prior to the provision of specialty mental health services under this chapter, unless another time frame is provided in the contract between the department and the MHP. For organizational providers, the MHP's certification process shall include an on site review in addition to a review of relevant documentation.

(e) When an organizational provider is the MHP, the department shall certify that each specific office or facility owned or operated by the MHP meets the applicable criteria in subsections (b), (c), or the contract between the department and the MHP. Unless another time frame is provided in the contract between the department and the MHP, the department's certification shall be obtained by the MHP prior to use of the provider for the provision of specialty mental health services under this chapter. The department's certification process shall include an on-site review of the office or facility in addition to a review of relevant documentation.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Section 5777 and 14684, Welfare and Institutions Code

1810.438 Alternative Contracts between MHPs and Providers.

(a) The MHP shall request approval from the department to establish a contract with a provider for specialty mental health services where that provider is held financially responsible for specialty mental health services provided to beneficiaries by one or more other providers.

(b) The MHP may request approval from the department under this section by submitting a written request to the department containing a description of:

(1) The proposed contract terms concerning reimbursement,

(2) A complete description of the administrative system of the provider and the MHP that will ensure proper payment to the provider, claiming of the FFP available for services provided to Medi-Cal beneficiaries under the Medi-Cal program, and MHP cost report settlement.

(c) The MHP shall not implement the proposed contract terms until written approval by the department is received. The department shall review the proposal and approve the request only if the following conditions are met:

(1) The proposed contract complies with federal and state requirements for reimbursement for specialty mental health services.

(2) The MHP has established appropriate systems to prevent duplicate claiming of FFP.

(3) The MHP has established appropriate procedures to assure that services provided under the contract are reported by only one provider in cost and data reporting to the department.

(d) Nothing in this section shall exclude or exempt a provider from compliance with any applicable licensing requirements for health care service plans and specialized health care service plans under Health and Safety Code, Section 1340 et seq.

(e) For contracts executed before November 1, 1997 that meet the criteria of subsection (a) the MHP shall request approval from the department no later than July 1, 1998 or the date the contract is amended to change the reimbursement method, whichever is earlier. Nothing in this subsection shall preclude the department from reviewing any contracts for compliance with other applicable laws and regulations pursuant to Section 1810.380.

(f) A negotiated rate of payment between an MHP and a provider pursuant to this section shall not be the basis for finding a violation of the requirements of Title 22, Section 51501(a) or Section 51480 and shall not be the basis for otherwise reducing the provider's reimbursement pursuant to Title 22, Division 3, Subdivision 1, Chapter 3, Article 7.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Section 1340 et seq., Health and Safety Code, and Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1810.440. MHP Quality Management Programs.

The MHP shall establish a Quality Management Program in accordance with the terms of the contract between the MHP and the department that includes at least the following elements:

(a) A Quality Improvement Program responsible for reviewing the quality of specialty mental health services provided to beneficiaries by the MHP that:

(1) Is accountable to the director of the MHP.

(2) Has active involvement in planning, design and execution from:

(A) Providers;

(B) Beneficiaries who have accessed specialty mental health services through the MHP; and

(C) Parents, spouses, relatives, legal representatives, or other persons similarly involved with beneficiaries who have accessed specialty mental health services.

(3) Includes substantial involvement of a licensed mental health professional.

(4) Conducts monitoring activities including but not limited to review of beneficiary complaints and grievances and fair hearings, provider appeals, and clinical records review.

(5) Is reviewed by the MHP and revised as appropriate annually.

(b) A Utilization Management Program responsible for assuring that beneficiaries have appropriate access to specialty mental health services from the MHP that:

(1) Assures that the access and authorization criteria established in this chapter are met.

(2) Conducts monitoring activities to ensure that the MHP meets the established standards for authorization decision making and takes action to improve performance if necessary.

(3) Is reviewed by the MHP and revised as appropriate annually.

(c) A beneficiary documentation and medical record system that meets the requirements of the contract between the MHP and the department and any applicable requirements of state and federal law and regulation.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14683, and 14684, Welfare and Institutions Code.

Subchapter 2. Medi-Cal Psychiatric Inpatient Hospital Services.

Article 2. Provision of Services.

1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

(a) For Medi-Cal reimbursement for an admission to a psychiatric inpatient hospital, the beneficiary shall meet medical necessity criteria set forth in (1) and (2) below:

(1) One of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy or Early Childhood

(D) Tic Disorders

(E) Elimination Disorders

- (F) Other Disorders of Infancy, Childhood, or Adolescence
- (G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
- (H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
- (I) Schizophrenia and Other Psychotic Disorders
- (J) Mood Disorders
- (K) Anxiety Disorders
- (L) Somatoform Disorders
- (M) Dissociative Disorders
- (N) Eating Disorders
- (O) Intermittent Explosive Disorder
- (P) Pyromania
- (Q) Adjustment Disorders
- (R) Personality Disorders

(2) A beneficiary must have both (A) and (B):

(A) Cannot be safely treated at a lower level of care; and

(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either 1 or 2 below:

1. Has symptoms or behaviors due to a mental disorder that (one of the following):
 - a. Represent a current danger to self or others, or significant property destruction.
 - b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.
 - c. Present a severe risk to the beneficiary's physical health.
 - d. Represent a recent, significant deterioration in ability to function.
2. Require admission for one of the following:

- a. Further psychiatric evaluation.
- b. Medication treatment.
- c. Other treatment that can reasonably be provided only if the patient is hospitalized.

(b) Continued stay services in a psychiatric inpatient hospital shall only be reimbursed when a beneficiary experiences one of the following:

(1) Continued presence of indications which meet the medical necessity criteria as specified in (a).

(2) Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.

(3) Presence of new indications which meet medical necessity criteria specified in (a).

(4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a psychiatric inpatient hospital.

(c) An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1820.215. MHP Payment Authorization - General Provisions.

(a) The MHP payment authorization shall be determined for

(1) Fee-for-Service/Medi-Cal hospitals, by an MHP's Point of Authorization.

(2) For Short-Doyle/Medi-Cal hospitals contracting with the MHP, by either:

(A) An MHP's Point of Authorization, or

(B) The hospital's Utilization Review Committee, as agreed to in the contract.

(3) For Short-Doyle/Medi-Cal hospitals that do not have a contract with the MHP, by an MHP's Point of Authorization.

(b) The MHP that approves the MHP payment authorization shall have financial responsibility as described in this chapter for the services authorized, unless financial responsibility is assigned to another entity pursuant to Sections 1850.405 and 1850.505 or unless the services are provided to

individuals eligible for the County Medical Services Program. Services provided to individuals eligible for the County Medical Services Program shall be authorized by the MHP for that county, but the MHP will not be responsible for payment of those services.

(c) MHP payment authorization requests presented for authorization beyond the timelines specified in this subchapter shall be accepted for consideration by the MHP only when the MHP determines that the hospital was prevented from submitting a timely request because of a reason that meets one of the criteria specified in subsections (1) and (2). The hospital shall submit factual documentation deemed necessary by the MHP with the MHP payment authorization request. Any additional documentation requested by the MHP shall be submitted within 60 calendar days of the MHP's request. The documentation shall verify that the late submission was due to:

(1) A natural disaster which has:

(A) Destroyed or damaged the hospital's business office or records, or

(B) Substantially interfered with the hospital's agent's processing of requests for MHP payment authorization; or

(2) Delays caused by other circumstances beyond the hospital's control which have been reported to an appropriate law enforcement or fire agency when applicable. Circumstances which shall not be considered beyond the control of the hospital include but are not limited to:

(A) Negligence by employees.

(B) Misunderstanding of program requirements.

(C) Illness or absence of any employee trained to prepare MHP payment authorizations.

(D) Delays caused by the United States Postal Service or any private delivery service.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1820.220. MHP Payment Authorization by a Point of Authorization.

(a) A hospital shall submit a separate written request for MHP payment authorization of psychiatric inpatient hospital services to the Point of Authorization of the beneficiary's MHP for each of the following:

(1) The planned admission of a beneficiary.

(2) Ninety-nine calendar days of continuous service to a beneficiary, if the hospital stay exceeds that period of time.

(3) Upon discharge.

(4) Services that qualify for Medical Assistance Pending Fair Hearing (Aid Paid Pending).

(5) Administrative day services that are requested for a beneficiary.

(b) A hospital shall submit the request for MHP payment authorization for psychiatric inpatient hospital services to the Point of Authorization of the beneficiary's MHP not later than:

(1) Prior to a planned admission.

(2) Within 14 calendar days after :

(A) Ninety-nine calendar days of continuous service to a beneficiary if the hospital stay exceeds that period of time.

(B) Discharge.

(C) The date that a beneficiary qualifies for Medical Assistance Pending Fair Hearing (Aid Paid Pending).

(c) A written request for MHP payment authorization to the Point of Authorization shall be in the form of:

(1) A Treatment Authorization Request (TAR) for Fee-for-Service/Medi-Cal hospitals; or

(2) As specified by the MHP for Short-Doyle/Medi-Cal hospitals.

(d) The Point of Authorization staff that approve or deny payment shall be licensed mental health or waived/registered professionals of the beneficiary's MHP.

(e) Approval or disapproval for each MHP payment authorization shall be documented by the Point of Authorization in writing:

(1) On the same TAR on which the Fee-for-Service/ Medi-Cal hospital requested MHP payment authorization or

(2) In an MHP payment authorization log maintained by the MHP for Short-Doyle/Medi-Cal hospitals.

(f) The MHP shall document that all adverse decisions regarding hospital requests for MHP payment authorization based on medical necessity criteria or the criteria for emergency admission were reviewed and approved:

(1) by a physician, or

(2) at the discretion of the MHP, by a psychologist for patients admitted by a psychologist and who received services under his/her scope of practice.

(g) A request for an MHP payment authorization may be denied by a Point of Authorization if the request is not submitted in accordance with timelines in this subchapter or does not meet applicable medical necessity reimbursement criteria or emergency psychiatric condition criteria on an emergency admission or if the hospital has failed to meet any other mandatory requirements of the contract negotiated between the hospital and the MHP.

(h) A Point of Authorization shall approve or deny the request for MHP payment authorization within 14 calendar days of the receipt of the request and, for a request from a Fee-for-Service Medi-Cal hospital, shall submit the TAR to the fiscal intermediary within 14 calendar days of approval or denial.

(i) Point of Authorization staff may authorize payments for up to seven calendar days in advance of service provision.

(j) Approval of the MHP payment authorization by a Point of Authorization requires that:

(1) Planned admission requests for an MHP's payment authorization shall be approved when written documentation provided indicates that the beneficiary meets medical necessity criteria for reimbursement of psychiatric inpatient hospital services, as specified in Section 1820.205, any other applicable requirements of this subchapter, and any mandatory requirements of the contract negotiated between the hospital and the MHP. The request shall be submitted and approved prior to admission.

(2) Emergency admissions shall not be subject to prior MHP payment authorization.

(3) A request for MHP payment authorization for continued stay services shall be submitted to the Point of Authorization as follows:

(A) A contract hospital's request shall be submitted within the timelines specified in the contract. If the contract does not specify timelines, the contract hospital shall be subject to the same timeline requirements as the non-contract hospitals.

(B) A non-contract hospital's request shall be submitted to the Point of Authorization not later than:

1. Within 14 calendar days after the beneficiary is discharged from the hospital, or
2. Within 14 calendar days after a beneficiary has received 99 continuous calendar days of psychiatric inpatient hospital services

(4) Requests for MHP payment authorization for continued stay services shall be approved if written documentation has been provided to the MHP indicating that the beneficiary met the medical necessity reimbursement criteria for acute psychiatric inpatient hospital services for each day of service in addition to requirements for timeliness of notification and any mandatory requirements of the contract negotiated between the hospital and the MHP.

(5) Requests for MHP payment authorization for administrative day services shall be approved by an MHP when the following conditions are met in addition to requirements for timeliness of notification and any mandatory requirements of the contract negotiated between the hospital and the MHP:

(A) During the hospital stay, a beneficiary previously has met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services.

(B) There is no appropriate, non-acute treatment facility in a reasonable geographic area and a hospital documents contacts with a minimum of five appropriate, non-acute treatment facilities per week subject to the following requirements:

1. Point of Authorization staff may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.

2. The lack of placement options at appropriate, non-acute residential treatment facilities and the contacts made at appropriate facilities shall be documented to include but not be limited to:

- a. The status of the placement option.
- b. Date of the contact.
- c. Signature of the person making the contact.

(C) For beneficiaries also eligible under Medicare (Part A) who have received acute psychiatric inpatient hospital services which were approved for Medicare (Part A) coverage, the hospital has notified the Point of Authorization within 24 hours or as specified in the contract, prior to beginning administrative day services.

(6) Medical Assistance Pending Fair Hearing Decision requests for MHP payment authorization by a hospital shall be approved by an MHP when necessary documentation, as specified in Section 1850.215, is submitted.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1820.225. MHP Payment Authorization for Emergency Admissions by a Point of Authorization.

(a) The MHP shall not require a hospital to obtain prior MHP payment authorization for an emergency admission, whether voluntary or involuntary.

(b) The hospital providing emergency psychiatric inpatient hospital services shall assure that the beneficiary meets the criteria for medical necessity in Section 1820.205, and due to a mental disorder, is:

- (1) A danger to self or others, or
- (2) Immediately unable to provide for, or utilize, food, shelter or clothing.

(c) The hospital providing emergency psychiatric inpatient hospital services shall notify the MHP of the county of the beneficiary within 24 hours of the time of the admission of the beneficiary to the hospital, or within the timelines specified in the contract, if applicable.

(1) If the hospital cannot determine the MHP of the beneficiary, the hospital shall notify the MHP of the county where the hospital is located, within 24 hours of admission.

(2) The MHP for the county where the hospital is located shall assist the hospital to determine the MHP of the beneficiary. The hospital shall notify the MHP of the beneficiary within 24 hours of determination of the appropriate MHP.

(d) Requests for MHP payment authorization for an emergency admission shall be approved by an MHP when:

(1) A hospital notified the Point of Authorization within 24 hours of admission of a beneficiary to the hospital or within the time required by contract, if applicable.

(2) Written documentation has been provided to the MHP that certifies that a beneficiary met the criteria in (b) at the time of admission.

(3) Written documentation has been provided to the MHP that certifies a beneficiary met the criteria in (b) for the day of admission.

(4) A non-contract hospital includes documentation that the beneficiary could not be safely transferred to a contract hospital or a hospital owned or operated by the MHP of the beneficiary, if the transfer was requested by the MHP.

(5) Any mandatory requirements of the contract negotiated between the hospital and the MHP are met.

(e) After an emergency admission, the MHP of the beneficiary may:

(1) Transfer the beneficiary from a non-contract to a contract hospital or a hospital owned or operated by the MHP of the beneficiary as soon as it is safe to do so. An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.

(2) Choose to authorize continued stay with a non-contract hospital.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1820.230. MHP Payment Authorization by a Utilization Review Committee.

(a) MHP payment authorization for psychiatric inpatient hospital services provided by a Short-Doyle/Medi-Cal hospital, if not made by an MHP's Point of Authorization pursuant to Section 1820.220, shall be made by the hospital's Utilization Review Committee.

(1) The hospital's Utilization Review Committee shall meet the Federal requirements for participants pursuant to Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D.

(2) The decision regarding MHP payment authorization shall be documented in writing by the hospital's Utilization Review Committee.

(b) The hospital's Utilization Review Committee or its designee shall approve or deny the initial MHP payment authorization no later than the third working day from the day of admission.

(c) At the time of the initial MHP payment authorization, the hospital's Utilization Review Committee or its designee shall specify the date for the subsequent MHP payment authorization determination.

(d) Approval of MHP payment authorization by a hospital's Utilization Review Committee requires that:

(1) When documentation in the clinical record substantiates that the beneficiary met the medical necessity criteria, the hospital's Utilization Review Committee shall authorize payment for each day that services are provided.

(2) Requests for MHP payment authorization for administrative day services shall be approved by the hospital's Utilization Review Committee when both of the following conditions are met:

(A) During the hospital stay, a beneficiary previously had met medical necessity criteria for acute psychiatric inpatient hospital services.

(B) There is no appropriate, non-acute treatment facility within a reasonable geographic area and the hospital documents contacts with a minimum of five appropriate, non-acute treatment facilities per week for placement of the beneficiary subject to the following requirements.

1. The MHP or its designee can waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.

2. The lack of placement options at appropriate, residential treatment facilities and the contacts made at appropriate treatment facilities shall be documented to include but not be limited to:

- a. The status of the placement option.
- b. Date of the contact.
- c. Signature of the person making the contact.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

Subchapter 3. Specialty Mental Health Services Other Than Psychiatric Inpatient Hospital Services.

Article 2. Provision of Services.

1830.205. Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.

(a) The following medical necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this subchapter, except as specifically provided.

(b) The beneficiary must meet criteria outlined in (1), (2), and (3) below to be eligible for services:

(1) Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:

- (A) Pervasive Developmental Disorders, except Autistic Disorders
- (B) Disruptive Behavior and Attention Deficit Disorders
- (C) Feeding and Eating Disorders of Infancy and Early Childhood
- (D) Elimination Disorders

(E) Other Disorders of Infancy, Childhood, or Adolescence

(F) Schizophrenia and other Psychotic Disorders

(G) Mood Disorders

(H) Anxiety Disorders

(I) Somatoform Disorders

(J) Factitious Disorders

(K) Dissociative Disorders

(L) Paraphilias

(M) Gender Identity Disorder

(N) Eating Disorders

(O) Impulse Control Disorders Not Elsewhere Classified

(P) Adjustment Disorders

(Q) Personality Disorders, excluding Antisocial Personality Disorder

(R) Medication-Induced Movement Disorders related to other included diagnoses.

(2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:

(A) A significant impairment in an important area of life functioning.

(B) A probability of significant deterioration in an important area of life functioning.

(C) Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.

(3) Must meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in (2) above.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or
2. Prevent significant deterioration in an important area of life functioning, or
3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.

(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in subsection (b)(1) even if a diagnosis that is not included in subsection (b)(1) is also present.

NOTE: Authority cited: Section 14680, Welfare and Institution Code.

Reference: Section 5777 and 14684, Welfare and Institution Code.

1830.210. Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries under 21 Years of Age.

(a) For beneficiaries under 21 years of age who do not meet the medical necessity requirements of Section 1830.205(b)(2) and (3), medical necessity criteria for specialty mental health services covered by this subchapter shall be met when all of the following exist:

- (1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),
- (2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and
- (3) The requirements of Title 22, Section 51340(e)(3) are met; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3) and the requirements of Title 22, Section 51340(f) are met.

(b) The MHP shall not approve a request for an EPSDT Supplemental Specialty Mental Health Service under this section if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this subchapter.

(c) The MHP shall not approve a request for specialty mental health services under this section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the

beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14132, and 14684, Welfare and Institutions Code, and Title 42, Section 1396d(r), United States Code.

1830.215. MHP Payment Authorization.

(a) Except as provided in Sections 1830.245 and 1830.250, the MHP may require that providers obtain MHP payment authorization of any or all specialty mental health services covered by this subchapter as a condition of reimbursement for the service.

(1) The MHP's authorization function may be assigned to a person, an identified staffing unit, a committee, or an organizational executive who may delegate the authorization function; including any such persons or entities affiliated with a contracting provider to which the MHP has delegated the authorization function.

(2) The individuals who review and approve or deny requests from providers for MHP payment authorization shall be licensed mental health professionals or waived/registered professionals of the MHP of the beneficiary. Licensed psychiatric technicians and licensed vocational nurses may approve or deny such requests only when the provider indicates that the beneficiary to whom the specialty mental health services will be delivered has an urgent condition.

(b) The MHP may require that providers obtain MHP payment authorization prior to rendering any specialty mental health service covered by this subchapter as a condition of reimbursement for the service, except for those services provided to beneficiaries with emergency psychiatric conditions as provided in Sections 1830.230 and 1830.245.

(c) Notwithstanding the provisions of subsections (a) and (b), the MHP shall require that providers obtain MHP payment authorization for day rehabilitation, day treatment intensive and EPSDT supplemental specialty mental health services as required in the MHP contract with the Department, and in compliance with Title 42, Code of Federal Regulations (CFR) Part 438, Section 438.210, Subsections (a) and (b), as published in the June 14, 2002 Federal Register (Vol. 67, No. 115, Pages 41107 and 41108), which is hereby incorporated by reference.

(d) Whether or not the MHP payment authorization of a specialty mental health service is required pursuant to subsections (a) or (b), the MHP may require that providers notify the MHP of their intent to provide the service prior to the delivery of the service. If the MHP does require such notice, the MHP shall inform providers of this requirement by including the MHP requirement in a publication commonly available to all providers serving beneficiaries.

NOTE: Authority cited: Sections 5775, 14043.75 and 14680, Welfare and Institutions Code.

Reference: Sections 5718, 5767, 5776, 5777, 5778 and 14684, Welfare and Institutions Code; and

42 CFR Part 438, Section 438.210(a) and (b). (Amended to add new subsection (c) effective 7/1/03.)

1830.220. Authorization of Out-of-Plan Services.

(a) “Out-of-Plan Services” means specialty mental health services covered by this subchapter, other than psychiatric nursing facility services, provided to a beneficiary by providers other than the MHP of the beneficiary or a provider contracting with the MHP of the beneficiary.

(b) The MHP shall be required to provide out-of-plan services only under the following circumstances:

(1) When a beneficiary with an emergency psychiatric condition is admitted for psychiatric inpatient hospital services as described in Section 1820.225 to the extent provided in Section 1830.230.

(2) When a beneficiary with an emergency psychiatric condition is admitted for psychiatric health facility services under the conditions described in Section 1830.245.

(3) When a beneficiary is out of county and develops an urgent condition and there are no providers contracting with the MHP reasonably available to the beneficiary based on the MHP’s evaluation of the needs of the beneficiary, especially in terms of timeliness of service.

(4) When there are no providers contracting with the MHP reasonably available to the beneficiary based on the MHP’s evaluation of the needs of the beneficiary, the geographic availability of providers, and community standards for availability of providers in the county in which the beneficiary is placed and the beneficiary is placed out of county by:

(A) The Foster Care Program as described in Article 5 (commencing with Section 11400), Chapter 2, Part 3, Division 9 of the Welfare and Institutions Code, the Adoption Assistance Program as described in Chapter 2.1 (commencing with Section 16115), Part 4, Division 9 of the Welfare and Institutions Code, or other foster care arrangement,

(B) A Lanterman-Petris-Short or Probate Conservator or other legal involuntary placement.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 11400, 14684, and 16115, Welfare and Institutions Code.

1830.225. Initial Selection and Change of Person Providing Services.

(a) Whenever feasible, the MHP of the beneficiary, at the request of the beneficiary, shall provide a beneficiary who has been determined by the MHP to meet the medical necessity criteria for outpatient psychiatrist, psychologist, EPSDT supplemental specialty mental health, rehabilitative or targeted case management services an initial choice of the person who will provide the service to the beneficiary. The MHP may limit the beneficiary’s choice, at the

election of the MHP, to a choice between two of the individual providers contracting with the MHP or a choice between two of the persons providing services who are employed by, contracting with or otherwise made available by the group or organizational provider to whom the MHP has assigned the beneficiary.

(b) Whenever feasible, the MHP of the beneficiary, at the request of the beneficiary, shall provide beneficiaries an opportunity to change persons providing outpatient psychiatrist, psychologist, EPSDT supplemental specialty mental health, rehabilitative, or targeted case management services. The MHP may limit the beneficiary's choice of another person to provide services, at the election of the MHP, to an individual provider contracting with the MHP or to another person providing services who is employed by, contracting with or otherwise made available by the group or organizational provider to whom the MHP has assigned the beneficiary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14681, 14683, and 14684, Welfare and Institutions Code.

Subchapter 4. Federal Financial Participation.

Article 1. General

1840.112. MHP Claims Certification and Program Integrity.

(a) Each MHP shall comply with all state and federal statutory and regulatory requirements for certification of claims, including Title 42, Code of Federal Regulations (CFR) Part 438, Sections 438.604, 438.606, and, as effective August 13, 2003, Section 438.608, as published in the June 14, 2002 Federal Register (Vol. 67, No. 115, Page 41112), which are hereby incorporated by reference.

(b) Each MHP shall certify to the Department, in writing, each monthly claim prior to submission to the State for reimbursement. The certification shall attest to the following for each beneficiary with services included in the claim:

(1) An assessment of the beneficiary was conducted in compliance with the requirements established in the MHP contract with the Department.

(2) The beneficiary was eligible to receive Medi-Cal services at the time the services were provided to the beneficiary.

(3) The services included in the claim were actually provided to the beneficiary.

(4) Medical necessity was established for the beneficiary as defined under this chapter for the service or services provided, for the timeframe in which the services were provided.

(5) A client plan was developed and maintained for the beneficiary that met all client plan requirements established in the MHP contract with the Department.

(6) For each beneficiary with day rehabilitation, day treatment intensive or EPSDT supplemental specialty mental health services included in the claim, all requirements for MHP payment authorization in the MHP contract for day rehabilitation, day treatment intensive and EPSDT supplemental specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in the MHP contract with the Department.

NOTE: Authority: Sections 5775, 14043.75 and 14680, Welfare and Institutions Code. Reference: Sections 5718, 5719, 5724, 5767, 5776, 5777, 5778 and 14684, Welfare and Institutions Code; and 42 CFR Part 433, Section 433.51, Part 438, Sections 438.604, 438.606 and 438.608, and Part 455, Section 455.18. (Adopted 7-1-03)

Article 3. Specialty Mental Health Services Other than Psychiatric Inpatient Hospital Services.

1840.304. Crosswalk between Service Functions and HCPCS Codes.

(a) When a provider bills the MHP for psychiatrist, psychologist, or EPSDT Supplemental Specialty Mental Health Services using a CPT or other HCPCS code in column A, then the MHP shall claim FFP based on the service function in column B at the units of time listed in column C. The dollar amount claimed shall be in accordance with Section 1840.105.

NOTE: Table deleted. See MHP contract, Exhibit A, Attachment 1, Section ____ for current reference.

(b) When a provider that is a hospital outpatient department bills the MHP for facility room use using the HCPCS codes Z7500 or Z7502 in addition to the CPT or other HCPCS code applicable to the specialty mental health service provided to the beneficiary, the MHP shall claim FFP for the combined codes under the applicable CPT or other HCPCS codes listed on the table in subsection (a). When a provider bills the MHP using a CPT or other HCPCS code that is not included on the table in section (a) other than Z7500 or Z7502, the MHP shall determine the appropriate service function for the service provided and shall claim FFP in accordance with Section 1840.308.

(c) An MHP may define a HCPCS code differently than defined in this subchapter in a contract between the MHP and a provider, provided the definition in the contract is not substantially different from the definition in this subchapter. Requiring that a provider other than a physician use a CPT code to bill for a therapy service shall not be considered to be substantially different.

(d) The lockouts described in Section 1840.215 and Sections 1840.360 through 1840.374 shall apply to claiming of FFP for services claimed under this section. For the purpose of determining lockouts the service shall be considered to be the service identified in column B at the units of time listed in column C.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Section 5778, Welfare and Institutions Code.

1840.318. Claiming for Service Functions Based on Half Days or Full Days of Time.

(a) Day treatment intensive and day rehabilitation shall be billed as half days or full days of service.

(b) The following requirements apply for claiming of services based on half days or full days of time:

(1) A half day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.

(2) A full day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available more than four hours per day.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Section 5778, Welfare and Institutions Code.

1840.328. Day Treatment Intensive Services Contact and Site Requirements.

Day Treatment Intensive Services shall have a clearly established site for services, although all services need not be delivered at that site.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Section 5778, Welfare and Institutions Code.

1840.330. Day Rehabilitation Services Contact and Site Requirements.

Day Rehabilitation Services shall have a clearly established site for services, although all services need not be delivered at that site.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Section 5778, Welfare and Institutions Code.

1840.350. Day Treatment Intensive Staffing Requirements.

(a) At a minimum there must be an average ratio of at least one person from the following list providing Day Treatment Intensive services to eight beneficiaries or other clients in attendance during the period the program is open.

(1) Physicians

(2) Psychologists or related waived/registered professionals.

- (3) Licensed Clinical Social Workers or related waived/registered professionals.
- (4) Marriage, Family and Child Counselors or related waived/registered professionals.
- (5) Registered Nurses
- (6) Licensed Vocational Nurses
- (7) Psychiatric Technicians
- (8) Occupational Therapists
- (9) Mental Health Rehabilitation Specialists as defined in Section 630.

(b) Persons who are not solely used to provide Day Treatment Intensive services may be utilized according to program need, but shall not be included as part of the above ratio formula. The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Treatment Intensive services and function in other capacities.

(c) Persons providing services in Day Treatment Intensive programs serving more than 12 clients shall include at least one person from each of two of the following groups:

- (1) Physicians
- (2) Psychologists or related waived/registered professionals.
- (3) Licensed Clinical Social Workers or related waived/registered professionals.
- (4) Marriage, Family and Child Counselors or related waived/registered professionals.
- (5) Registered Nurses
- (6) Licensed Vocational Nurses
- (7) Psychiatric Technicians
- (8) Occupational Therapists
- (9) Mental Health Rehabilitation Specialists as defined in Section 630.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Section 5778, Welfare and Institutions Code.

1840.352. Day Rehabilitation Staffing Requirements.

(a) At a minimum there must be an average ratio of at least one person from the following list providing Day Rehabilitation services to ten beneficiaries or other clients in attendance during the period the program is open.

- (1) Physicians
- (2) Psychologists or related waived/registered professionals.
- (3) Licensed Clinical Social Workers or related waived/registered professionals.
- (4) Marriage, Family and Child Counselors or related waived/registered professionals.
- (5) Registered Nurses
- (6) Licensed Vocational Nurses
- (7) Psychiatric Technicians
- (8) Occupational Therapists
- (9) Mental Health Rehabilitation Specialists as defined in Section 630.

(b) Persons who are not solely used to provide Day Rehabilitation services may be utilized according to program need, but shall not be included as part of the above ratio formula. The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Rehabilitation services and function in other capacities.

(c) Persons providing services in Day Rehabilitation programs serving more than 12 clients shall include at least two of the following:

- (1) Physicians
- (2) Psychologists or related waived/registered professionals.
- (3) Licensed Clinical Social Workers or related waived/registered professionals.
- (4) Marriage, Family and Child Counselors or related waived/registered professionals.
- (5) Registered Nurses
- (6) Licensed Vocational Nurses
- (7) Psychiatric Technicians

(8) Mental Health Rehabilitation Specialists as defined in Section 630.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Section 5778, Welfare and Institutions Code.

Subchapter 5. Problem Resolution Processes

1850.205. Beneficiary Problem Resolution Processes.

(a) An MHP shall develop problem resolution processes that enable a beneficiary to resolve a concern or complaint about any specialty mental health service-related issue.

(b) The MHP's beneficiary problem resolution processes shall include:

(1) A complaint resolution process.

(2) A grievance process.

(c) For both the complaint resolution process and the grievance process, the MHP shall ensure:

(1) That each beneficiary has adequate information about the MHP's processes by taking at least the following actions:

(A) Including information describing the complaint resolution process and the grievance process in the MHP's beneficiary brochure and providing the beneficiary brochure to beneficiaries as described in Section 1810.360.

(B) Posting notices explaining complaint resolution and grievance process procedures in locations at all MHP provider sites sufficient to ensure that the information is readily available to both beneficiaries and provider staff. For the purposes of this section, an MHP provider site means any office or facility owned or operated by the MHP or a provider contracting with the MHP at which beneficiaries may obtain specialty mental health services.

(C) Making grievance forms and self addressed envelopes available for beneficiaries to pick up at all MHP provider sites without having to make a verbal or written request to anyone.

(2) That a beneficiary may authorize another person to act on the beneficiary's behalf.

(3) That a beneficiary's legal representative may use the complaint resolution process or the grievance process on the beneficiary's behalf.

(4) That an MHP staff person or other individual is identified as having responsibility for assisting a beneficiary with these processes at the beneficiary's request.

(5) That a beneficiary is not subject to discrimination or any other penalty for filing a complaint or grievance.

(6) That procedures for the processes maintain the confidentiality of beneficiaries.

(7) That a procedure is included by which issues identified as a result of the complaint resolution or grievance process are transmitted to the MHP's Quality Improvement Committee, the MHP's administration or another appropriate body within the MHP for review and, if applicable, implementation of needed system changes.

(d) In addition to meeting the requirements of subsection (c), the complaint resolution process shall, at a minimum:

(1) Provide for resolution of a beneficiary's concerns or complaints as quickly and simply as possible.

(2) Involve simple, informal and easily understood procedures that do not require beneficiaries to present their concerns or complaints in writing.

(3) Inform a beneficiary of his or her right to use the grievance process or request a fair hearing at any time before, during or after the complaint resolution process has begun.

(4) Identify the roles and responsibilities of the MHP, the provider and the beneficiary.

(e) In addition to meeting the requirements of subsection (c), the grievance process shall, at a minimum:

(1) Require that beneficiaries provide their concerns or complaints to the MHP as a written grievance.

(2) Provide for two levels of review within the MHP.

(3) Provide for a decision on the grievance at each level of review within 30 calendar days of receipt of the grievance by that level of review within the MHP.

(4) Provide for an expedited review of grievances where the beneficiary is grieving a decision by a provider or the MHP to discontinue adult residential or crisis residential services. When the written grievance is received by the MHP prior to the beneficiary's discharge from the services, the beneficiary shall continue to receive the adult residential or crisis stabilization services and the MHP shall continue payment for the services until the MHP responds to the grievance at the first level of review, at which point action may be taken by the provider or the MHP as appropriate based on the grievance decision. Services shall not be continued if the provider or the MHP determines that ongoing placement of the beneficiary in that facility poses a danger to the beneficiary or others.

(5) Identify the roles and responsibilities of the MHP, the provider and the beneficiary.

(6) Provide for:

(A) Recording the grievance in a grievance log within one working day of the date of receipt of the grievance. The log entry shall include but not be limited to:

1. The name of the beneficiary.
2. The date of receipt of the grievance.
3. The nature of the problem.

(B) Recording the final disposition of a grievance, including the date the decision is sent to the beneficiary, or documenting the reason(s) that there has not been final disposition of the grievance.

(C) An MHP staff person or other individual with responsibility to provide information on request by the beneficiary or an appropriate representative regarding the status of the beneficiary's grievance.

(D) Notifying the beneficiary or the appropriate representative in writing of the grievance decision and documenting the notification or efforts to notify the beneficiary, if he or she could not be contacted. When the notice contains the decision of the MHP's first level of review, the notice shall include the beneficiary's right to appeal to the second level of review and to request a fair hearing if the beneficiary disagrees with the decision instead of, before, during or after filing the grievance at the second level of review. When the notice contains the decision of the MHP's second level of review, the notice shall include the beneficiary's right to request a fair hearing if the beneficiary disagrees with the decision.

(E) If any providers were cited by the beneficiary or otherwise involved in the grievance, notifying those providers of the final disposition of the beneficiary's grievance.

(f) An MHP's grievance log and any other grievance process files, and any complaint resolution process files shall be open to review by the department, the State Department of Health Services, and any appropriate oversight agency.

(g) Nothing in this section precludes a provider other than the MHP from establishing complaint or grievance processes for beneficiaries receiving services from that provider. When such processes exist, beneficiaries shall not be required by the MHP to use or exhaust the provider's processes prior to using the MHP's beneficiary problem resolution process, unless the following conditions have been met:

(1) The MHP delegates the responsibility for the beneficiary problem resolution process to the provider in writing, specifically outlining the provider's responsibility under the delegation.

(2) The provider's beneficiary problem resolution process fully complies with this section.

(3) No beneficiary is prevented from accessing the grievance process solely on the grounds that the grievance was incorrectly filed with either the MHP or the provider.

(h) No provision of an MHP's beneficiary problem resolution processes shall be construed to replace or conflict with the duties of county patients' rights advocates as described in Welfare and Institutions Code, Section 5520.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5520 and 14684, Welfare and Institutions Code.

1850.210. Fair Hearing and Notice of Action.

(a) The MHP shall provide a beneficiary of the MHP with a Notice of Action when the MHP acts to deny an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. Notice in response to an initial request from a provider shall be provided in accordance with this subsection. Notice in response to a request for continuation of a specialty mental health service shall be provided in accordance with Title 22, Section 51014.1. The Notice of Action under this subsection shall not be required in the following situations:

(1) The denial is a denial of a request for MHP payment authorization for a specialty mental health service that has already been provided to the beneficiary.

(2) The denial is a non-binding verbal description to a provider of the specialty mental health services which may be approved by the MHP.

(b) The MHP of the beneficiary shall provide the beneficiary with a Notice of Action when the MHP defers action on an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. The Notice of Action shall be delayed for 30 calendar days to allow the provider of the specialty mental health service time to submit the additional information requested by the MHP and to allow time for the MHP to make a decision. If, after 30 calendar days from the MHP's receipt of the MHP payment authorization request, the provider has not complied with the MHP's request for additional information, the MHP shall provide the beneficiary a notice of action to deny the service pursuant to subdivision (a). If, within that 30 day period, the provider does comply, the MHP shall take appropriate action on the MHP payment authorization request as supplemented by the additional information, including providing a Notice of Action to the beneficiary if the service is denied or modified or if the MHP defers action on the MHP payment authorization request for an additional period of time. The Notice of Action under this subsection shall not be required when the MHP defers action on an MHP payment authorization request for a specialty mental health service that has already been provided to the beneficiary.

(c) The MHP shall provide a beneficiary of the MHP with a Notice of Action when the MHP modifies an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. Notice in response to an initial request from a provider shall be provided in accordance with Title 22, Section 51014.1. The Notice of Action pursuant to this subsection shall not be required when the MHP modifies the duration of any approved specialty mental health services as long as the MHP provides an opportunity for the provider to request MHP payment authorization of additional specialty mental health services before the end of the approved duration of services. The Notice of Action under this subsection shall not be required when the MHP modifies an MHP payment authorization request for a specialty mental health service that has already been provided to the beneficiary.

(d) The written Notice of Action issued pursuant to subsections (a), (b), or (c) shall be deposited with the United States postal service in time for pick-up no later than the third working day after the action and shall specify:

(1) The action taken by the MHP.

(2) The reason for the action taken.

(3) A citation of the specific regulations or MHP payment authorization procedures supporting the action.

(4) The beneficiary's right to a fair hearing, including:

(A) The method by which a hearing may be obtained.

(B) That the beneficiary may be either:

1. Self-represented.

2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(C) An explanation of the circumstances under which a specialty mental health service will be continued if a fair hearing is requested.

(D) The time limits for requesting fair hearing.

(e) The fair hearings under this section shall be administered by the State Department of Health Services.

(f) For the purpose of this section, each reference to Medi-Cal managed care plan in Title 22, Section 51014.1, shall mean the MHP.

(g) For the purposes of this section, "medical service" as cited in Title 22, Section 51014.1, shall mean those specialty mental health services that are subject to prior authorization by an MHP pursuant to subchapters 2 and 3.

(h) The provisions of this section do not apply to the decisions of providers including the MHP serving beneficiaries when prior authorization of the service by the MHP's authorization procedures is not a condition of payment to the provider for the specialty mental health service.

(i) When a Notice of Action would not be required under subsections (a), (b), or (c), the MHP of the beneficiary shall provide a beneficiary with Notice of Action under this subsection when the MHP or its providers determine that the medical necessity criteria in Section 1830.205(b)(1), (b)(2) or (b)(3)(C) or Section 1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the MHP. The Notice of Action under this subsection, shall, at the election of the MHP, be hand delivered to the beneficiary on the date of the action or mailed to the beneficiary in accordance with subsection (d) and shall specify:

- (1) The reason the medical necessity criteria was not met.
- (2) The beneficiary's options for obtaining care outside the MHP, if applicable.
- (3) The beneficiary's right to request a second opinion on the determination.
- (4) The beneficiary's right to file a complaint or grievance with the MHP.
- (5) The beneficiary's right to a fair hearing, including:
 - (A) The method by which a hearing may be obtained.
 - (B) That the beneficiary may be either:
 1. Self-represented.
 2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.
 - (C) The time limits for requesting fair hearing.

NOTE: Authority cited: Section 14684, Welfare and Institutions Code.
Reference: Section 14684, Welfare and Institutions Code.

1850.215. Medical Assistance for Beneficiary Pending Fair Hearing Decision.

A beneficiary receiving specialty mental health services pursuant to this chapter shall have a right to file for continuation of specialty mental health services pending fair hearing pursuant to Title

22, Section 51014.2. For the purpose of this section, each reference to Medi-Cal managed care plan in Title 22, Section 51014.2, shall mean the MHP. The time limits for filing for a continuation of services pursuant to Title 22, Section 51014.2 shall not be extended by a beneficiary's decision to pursue an MHP's beneficiary problem resolution process as described in Section 1850.205.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Section 14684, Welfare and Institutions Code.

1850.305 Provider Problem Resolution and Appeal Processes.

(a) An MHP shall develop provider problem resolution and appeal processes that enable providers to resolve MHP payment authorization issues or other complaints and concerns.

(b) The MHP shall ensure that participating providers are provided written information regarding the provider problem resolution and appeal processes.

(c) The Provider Problem Resolution Process shall include, at a minimum:

(1) A means to identify and resolve provider concerns and problems quickly and easily.

(2) Utilize simple, informal, and easily understood procedures.

(3) Inform providers of their right to access the Provider Appeal Process at any time before, during, or after the Provider Problem Resolution Process has begun when the complaint concerns a denied or modified request for MHP payment authorization or the processing or payment of a provider's claim to the MHP.

(d) The Provider Appeal Process shall include the following:

(1) A provider may appeal a denied or modified request for MHP payment authorization or a dispute with the MHP concerning the processing or payment of a provider's claim to the MHP. The written appeal shall be submitted to the MHP within 90 calendar days of the date of receipt of the non-approval of payment or within 90 calendar days of the MHP's failure to act on the request in accordance with the time frames required by Sections 1820.220 or 1830.250, or established by the MHP pursuant to Section 1830.215.

(2) The MHP shall have 60 calendar days from its receipt of the appeal to inform the provider in writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.

(A) If the appeal concerns the denial or modification of an MHP payment authorization request, the MHP shall utilize personnel not involved in the initial denial or modification decision to determine the appeal decision.

(B) If the appeal is not granted in full, the provider shall be notified of any right to submit an appeal to the department pursuant to subsection (e).

(C) If applicable, the provider shall submit a revised request for MHP payment authorization within 30 calendar days from receipt of the MHP's decision to approve the MHP payment authorization request.

(D) If applicable, the MHP shall have 14 calendar days from the date of receipt of the provider's revised request for MHP payment authorization to submit the TAR to the fiscal intermediary for processing.

(3) If an MHP does not respond within 60 calendar days to the appeal, the appeal shall be considered denied by the MHP. If applicable under subsection (e), the provider may appeal directly to the department.

(e) When an appeal concerning the denial or modification of an MHP payment authorization request for the specialty mental health services provided in an emergency as described in Sections 1820.225, 1830.230, and 1830.245 is denied in full or in part by the MHP's Provider Appeal Process on the basis that the provider did not comply with the required timelines for notification or submission of the MHP payment request or that the medical necessity criteria were not met, the provider may appeal the denial or modification to the department.

(1) Hospitals and the individual, group or organizational providers who have provided specialty mental health services under Sections 1820.225, 1830.230, and 1830.245 to a beneficiary during the psychiatric inpatient hospital stay that is the subject of the appeal may appeal separately to the department unless they have agreed to another arrangement as a term of their contract with the MHP.

(2) If a provider chooses to appeal to the department an MHP's denial of MHP payment authorization, the appeal shall be submitted in writing, along with supporting documentation, within 30 calendar days from the date of the MHP's written decision of denial. The provider may appeal to the department within 30 calendar days after 60 calendar days from submission to the MHP, if the MHP fails to respond. Supporting documentation shall include, but not be limited to:

(A) Any documentation supporting allegations of timeliness, if at issue, including fax records, phone records or memos.

(B) Clinical records supporting the existence of medical necessity if at issue.

(C) A summary of reasons why the MHP should have approved the MHP payment authorization.

(D) A contact person(s) name, address and phone number.

(3) The department shall notify the MHP and the provider of its receipt of a request for appeal pursuant to subsection (d) within seven calendar days. The notice to the MHP shall include a request to the MHP for specific documentation supporting denial of the MHP payment authorization and a request for documentation establishing any agreements with the appealing provider or other providers who may be affected by the appeal pursuant to subsection (d)(1).

(4) The MHP shall submit the requested documentation within 21 calendar days or the department shall decide the appeal based solely on the documentation filed by the provider.

(5) The department shall have 60 calendar days from the receipt of the MHP's documentation or from the 21st calendar day after the request for documentation, whichever is earlier, to notify the provider and the MHP, in writing, of its decision, including a statement of the reasons for the decision that addresses each issue raised by the provider and the MHP, and any actions required by the MHP or the provider to implement the decision. At the election of the provider, if the department fails to act within the 60 calendar days, the appeal may be considered to have been denied by the department.

(A) The department may allow both a provider representative(s) and the MHP representative(s) an opportunity to present oral argument to the department.

(B) If applicable, the provider shall submit a revised request for MHP payment authorization within 30 calendar days from receipt of the department's decision to uphold the appeal.

(C) If applicable, the MHP shall have 14 calendar days from the receipt of the provider's revised MHP payment authorization request to approve the MHP payment authorization or submit documentation to the Medi-Cal fiscal intermediary required to process the MHP payment authorization.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Section 14684, Welfare and Institutions Code.

1850.405. Resolution of Disputes between MHPs regarding MHP of Beneficiary.

(a) Under the following arbitration processes the MHP of the beneficiary may be determined to be different than that specified in the Medi-Cal Eligibility Data System (MEDS) file.

(b) Any two or more MHPs may develop an arbitration agreement to provide for determining final responsibility for MHP payment authorization as described in subchapters 2 and 3 when there is a dispute between the participating MHPs. Each arbitration agreement must:

- (1) Provide for the selection of an arbitrator.
- (2) Include timelines for filing and resolution.
- (3) Include criteria that will serve as a basis for a decision.

(4) Specify that decisions reached under the arbitration process will be final.

(5) Be signed by all participating MHPs or their designees.

(6) Require that all decisions of the arbitrator shall be in writing.

(7) Provide that a copy of each decision shall be forwarded to the affected MHPs within 14 calendar days of the decision.

(c) In cases where there is a disagreement between MHPs that are not participating in an arbitration process, the arbitration process shall be as follows:

(1) Each MHP shall provide the department with at least one individual available to serve as an arbitrator. The MHP shall confirm or update the available individuals annually. The department shall provide a listing of the available individuals to the MHPs annually by October 1. The parties to the dispute may agree to a single arbitrator. If the parties to the dispute cannot agree on a single arbitrator, the parties shall each select an arbitrator from the list of available individuals, except that an individual identified by either involved MHP may not be selected. The selected arbitrators shall select a third arbitrator who is not an individual identified by either involved MHP from the listing.

(2) The arbitrators' services shall be reimbursed at the hourly rate charge by the State Office of Administrative Hearings for hearings it conducts for other state agencies, not to exceed a total of ten hours. The parties shall share equally in paying for the arbitrators' services. Payment shall be made directly to the arbitrators unless the arbitrator is an employee of the MHP, in which case payment shall be made to that MHP.

(3) The arbitrators' decision as to the MHP of the beneficiary shall be based on a review of the facts in relation to the following criteria:

(A) If a beneficiary has moved to a county or acts to establish residency in a county and has a clear intent to reside in the county, the MHP for that county shall be considered the MHP of the beneficiary.

(B) If a beneficiary is a Lanterman-Petris-Short or Probate Conservatee, the MHP for the county in which the beneficiary is conserved shall be considered the MHP of the beneficiary.

(C) If a beneficiary has been placed in legal custody by a county, the MHP for the county that initiated the legal proceeding shall be considered the MHP of the beneficiary. If a beneficiary is on parole or in a conditional release program and is restricted to a particular area, the MHP for the county which includes the area to which the beneficiary is restricted shall be the MHP of the beneficiary.

(D) If a beneficiary has adopted a transient, nomadic lifestyle and has a clear intent to continue this lifestyle, the MHP for the county in which the beneficiary presents for services shall be considered the MHP of the beneficiary.

(E) If a beneficiary, because of the beneficiary's mental status, is unable to form or express a clear intent to reside anywhere, the following may be considered evidence that the MHP for the county involved would be the MHP of the beneficiary:

1. The county that originated residential, medical, or psychiatric placement.
2. The county in which the beneficiary has current housing.
3. The county that has paid general assistance to the beneficiary.
4. The county in which the beneficiary has received ongoing community mental health clinical care during the last six months.

(F) Where the facts do not clearly meet the criteria, the arbitrators' decision shall be reasonable in light of the facts presented using the criteria in (A) through (E) as a general guidelines.

(4) The affected MHPs shall provide relevant documentation to arbitrators no later than 21 calendar days after the arbitrators have been selected.

(5) The arbitrators shall decide on the issue no later 60 calendar days

(A) from the date documentation is received from the affected MHPs, or

(B) from 21 calendar days after the arbitrator has been selected, whichever is sooner.

(6) The arbitrators shall issue the decision in writing to the affected MHPs within 14 calendar days of the decision.

(d) When the arbitrators acting under either subsections (b) or (c) determine that an MHP is responsible for payment for specialty mental health services previously authorized by another MHP, the MHP found responsible for payment of services shall perform, within 14 calendar days from the date of the arbitrator's decision, any action required of the MHP to implement the decision of the arbitration process. The department reserves the right to take action necessary to implement the decision of the arbitration process if the MHP found to be responsible fails to comply with the decision.

(e) A dispute regarding the MHP of the beneficiary shall not delay medically necessary services to beneficiaries. The MHP of the beneficiary as identified on the MEDS file shall be responsible for providing or authorizing and paying for the service until the dispute is resolved.

DMH/MHP Boilerplate effective January 1, 2005

MHP Name
Contract Number: 04-_____-000
Exhibit E – Attachment 1
Page 52 of 52

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code

FEDERAL REGULATIONS CROSS-REFERENCED IN CONTRACT

Various Parts related to PART 438—MANAGED CARE

Sec. 422.128 Information on Advance Directives

(a) Each M+C organization must maintain written policies and procedures that meet the requirements for advance directives, as set forth in subpart I of part 489 of this chapter. For purposes of this part, advance directive has the meaning given the term in Sec. 489.100 of this chapter.

(b) An M+C organization must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the M+C organization.

(1) An M+C organization must provide written information to those individuals with respect to the following:

(i) Their rights under the law of the State in which the organization furnishes services (whether statutory or recognized by the courts of the State) to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Providers may contract with other entities to furnish this information but remain legally responsible for ensuring that the requirements of this section are met. The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the State law.

(ii) The M+C organization's written policies respecting the implementation of those rights, including a clear and precise statement of limitation if the M+C organization cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following:

(A) Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians.

(B) Identify the state legal authority permitting such objection.

(C) Describe the range of medical conditions or procedures affected by the conscience objection.

(D) Provide the information specified in paragraph (a)(1) of this section to each enrollee at the time of initial enrollment. If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the M+C organization may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accordance with State law. The M+C organization is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

(E) Document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive.

(F) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.

(G) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives.

(H) Provide for education of staff concerning its policies and procedures on advance directives.

(l) Provide for community education regarding advance directives that may include material required in paragraph (a)(1)(i) of this section, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the M+C organization. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State law concerning advance directives. An M+C organization must be able to document its community education efforts.

(2) The M+C organization--

(i) Is not required to provide care that conflicts with an advance directive; and

(ii) Is not required to implement an advance directive if, as a matter of conscience, the M+C organization cannot implement an advance directive and State law allows any health care provider or any agent of the provider to conscientiously object.

(3) The M+C organization must inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.

Sec. 489.100 Definition.

For purposes of this part, advance directive means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Sec. 431.244 Hearing decisions.

. . . .

(f) The agency must take final administrative action as follows:

(1) Ordinarily, within 90 days from the earlier of the following:

(i) The date the enrollee filed an MCO or PIHP appeal, not including the number of days the enrollee took to subsequently file for a State fair hearing; or

(ii) If permitted by the State, the date the enrollee filed for direct access to a State fair hearing.

(2) As expeditiously as the enrollee's health condition requires, but no later than 3 working days after the agency receives, from the MCO or PIHP, the case file and information for any appeal of a denial of a service that, as indicated by the MCO or PIHP—

(i) Meets the criteria for expedited resolution as set forth in Sec. 438.410(a) of this chapter, but was not resolved within the timeframe for expedited resolution; or

(ii) Was resolved within the timeframe for expedited resolution, but reached a decision wholly or partially adverse to the enrollee.

(3) If the State agency permits direct access to a State fair hearing, as expeditiously as the enrollee's health condition requires, but no later than 3 working days after the agency receives, directly from an MCO or PIHP enrollee, a fair hearing request on a decision to deny a service that it determines meets the criteria for expedited resolution, as set forth in Sec. 438.410(a) of this chapter. . . .

PART 438—MANAGED CARE

Subpart A—General Provisions

Sec. 438.6 Contract requirements.

- (a) Regional office review. The CMS Regional Office must review and approve all MCO, PIHP, and PAHP contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirement in Sec. 438.806.
- (b) Entities eligible for comprehensive risk contracts. (N/A)
- (c) Payments under risk contracts. (N/A)
- (d) Enrollment discrimination prohibited. (N/A)
- (f) Compliance with contracting rules. All contracts under this subpart must:
 - (1) Comply with all applicable Federal and State laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act; and
 - (2) Meet all the requirements of this section.
- (g) Inspection and audit of financial records. Risk contracts must provide that the State agency and the Department may inspect and audit any financial records of the entity or its subcontractors.
- (h) Physician incentive plans.
 - (1) MCO, PIHP, and PAHP contracts must provide for compliance with the requirements set forth in Secs. 422.208 and 422.210 of this chapter.
 - (2) In applying the provisions of Secs. 422.208 and 422.210 of this chapter, references to "M+C organization", "CMS", and "Medicare beneficiaries" must be read as references to "MCO, PIHP, or PAHP", "State agency" and "Medicaid recipients", respectively.
- (i) Advance directives.
 - (1) All MCO and PIHP contracts must provide for compliance with the requirements of Sec. 422.128 of this chapter for maintaining written policies and procedures for advance directives.
 - (2) All PAHP contracts must provide for compliance with the requirements of Sec. 422.128 of this chapter for maintaining written policies and procedures for advance directives if the PAHP includes, in its network, any of those providers listed in Sec. 489.102(a) of this chapter.
 - (3) The MCO, PIHP, or PAHP subject to this requirement must provide adult enrollees with written information on advance directives policies, and include a description of applicable State law.
 - (4) The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.
- (j) Special rules for certain HIOs. (N/A)
- (k) Additional rules for contracts with PCCMs. (N/A)
- (l) Subcontracts. All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.
- (m) Choice of health professional. The contract must allow each enrollee to choose his or her health professional to the extent possible and appropriate.

Sec. 438.10 Information requirements.

(a) Terminology. As used in this section, the following terms have the indicated meanings:
Enrollee means a Medicaid recipient who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program.

Potential enrollee means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, or PCCM.

(b) Basic rules.

- (1) Each State, enrollment broker, MCO, PIHP, PAHP, and PCCM must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.
- (2) The State must have in place a mechanism to help enrollees and potential enrollees understand the State's managed care program.
- (3) Each MCO and PIHP must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.
- (c) Language. The State must do the following:
 - (1) Establish a methodology for identifying the prevalent non- English languages spoken by enrollees and potential enrollees throughout the State. ``Prevalent" means a non-English language spoken by a significant number or percentage of potential enrollees and enrollees in the State.
 - (2) Make available written information in each prevalent non- English language.
 - (3) Require each MCO, PIHP, PAHP, and PCCM to make its written information available in the prevalent non-English languages in its particular service area.
 - (4) Make oral interpretation services available and require each MCO, PIHP, PAHP, and PCCM to make those services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent.
 - (5) Notify enrollees and potential enrollees, and require each MCO, PIHP, PAHP, and PCCM to notify its enrollees—
 - (i) That oral interpretation is available for any language and written information is available in prevalent languages; and
 - (ii) How to access those services.
- (d) Format. (1) Written material must—
 - (i) Use easily understood language and format; and
 - (ii) Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
- (2) All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.
- (e) Information for potential enrollees.
 - (1) The State or its contracted representative must provide the information specified in paragraph (e)(2) of this section to each potential enrollee as follows:
 - (i) At the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program.
 - (ii) Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs, PIHP, PAHPs, or PCCMs.
 - (2) The information for potential enrollees must include the following:
 - (i) General information about—
 - (A) The basic features of managed care;
 - (B) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program; and
 - (C) MCO, PIHP, PAHP, and PCCM responsibilities for coordination of enrollee care;
 - (ii) Information specific to each MCO, PIHP, PAHP, or PCCM program operating in potential enrollee's service area. A summary of the following information is sufficient, but the State must provide more detailed information upon request:
 - (A) Benefits covered.
 - (B) Cost sharing, if any.
 - (C) Service area.

(D) Names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs, this includes at a minimum information on primary care physicians, specialists, and hospitals.

(E) Benefits that are available under the State plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP, or PCCM does not cover because of moral or religious objections, the State must provide information about where and how to obtain the service.

(f) General information for all enrollees of MCOs, PIHPs, PAHPs, and PCCMs. Information must be furnished to MCO, PIHP, PAHP, and PCCM enrollees as follows:

(1) The State must notify all enrollees of their disenrollment rights, at a minimum, annually. For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 days before the start of each enrollment period.

(2) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must notify all enrollees of their right to request and obtain the information listed in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least once a year.

(3) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must furnish to each of its enrollees the information specified in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, within a reasonable time after the MCO, PIHP, PAHP, or PCCM receives, from the State or its contracted representative, notice of the recipient's enrollment.

(4) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must give each enrollee written notice of any change (that the State defines as "significant") in the information specified in paragraphs (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least 30 days before the intended effective date of the change.

(5) The MCO, PIHP, and, when appropriate, the PAHP or PCCM, must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

(6) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must provide the following information to all enrollees:

(i) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs this includes, at a minimum, information on primary care physicians, specialists, and hospitals.

(ii) Any restrictions on the enrollee's freedom of choice among network providers.

(iii) Enrollee rights and protections, as specified in Sec. 438.100.

(iv) Information on grievance and fair hearing procedures, and for MCO and PIHP enrollees, the information specified in Sec. 438.10(g)(1), and for PAHP enrollees, the information specified in Sec. 438.10(h).

(v) The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.

(vi) Procedures for obtaining benefits, including authorization requirements.

(vii) The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers.

(viii) The extent to which, and how, after-hours and emergency coverage are provided, including:

(A) What constitutes emergency medical condition, emergency services, and poststabilization services, with reference to the definitions in Sec. 438.114(a).

- (B) The fact that prior authorization is not required for emergency services.
- (C) The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
- (D) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services covered under the contract.
- (E) The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care.
- (ix) The poststabilization care services rules set forth at Sec. 422.113(c) of this chapter.
- (x) Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.
- (xi) Cost sharing, if any.
- (xii) How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP, or PCCM does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM need not furnish information on how and where to obtain the service. The State must provide information on how and where to obtain the service.
- (g) Specific information requirements for enrollees of MCOs and PIHPs. In addition to the requirements in Sec. 438.10(f), the State, its contracted representative, or the MCO and PIHP must provide the following information to their enrollees:
 - (1) Grievance, appeal, and fair hearing procedures and timeframes, as provided in Secs. 438.400 through 438.424, in a State-developed or State-approved description, that must include the following:
 - (i) For State fair hearing—
 - (A) The right to hearing;
 - (B) The method for obtaining a hearing; and
 - (C) The rules that govern representation at the hearing.
 - (ii) The right to file grievances and appeals.
 - (iii) The requirements and timeframes for filing a grievance or appeal.
 - (iv) The availability of assistance in the filing process.
 - (v) The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.
 - (vi) The fact that, when requested by the enrollee—
 - (A) Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and
 - (B) The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.
 - (vii) Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.
 - (2) Advance directives, as set forth in Sec. 438.6(i)(2).
 - (3) Additional information that is available upon request, including the following:
 - (i) Information on the structure and operation of the MCO or PIHP.
 - (ii) Physician incentive plans as set forth in Sec. 438.6(h) of this chapter.
 - (h) Specific information for PAHPs. . . .
 - (i) Special rules: States with mandatory enrollment under State plan authority—. . .

Subpart C--Enrollee Rights and Protections

Sec. 438.100 Enrollee rights.

- (a) General rule. The State must ensure that—

- (1) Each MCO and PIHP has written policies regarding the enrollee rights specified in this section; and
- (2) Each MCO, PIHP, PAHP, and PCCM complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees.
- (b) Specific rights—
- (1) Basic requirement. The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (b)(3) of this section.
- (2) An enrollee of an MCO, PIHP, PAHP, or PCCM has the following rights: The right to –
- (i) Receive information in accordance with Sec. 438.10.
- (ii) Be treated with respect and with due consideration for his or her dignity and privacy.
- (iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in Sec. 438.10(f)(6)(xiii).)
- (iv) Participate in decisions regarding his or her health care, including the right to refuse treatment.
- (v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
- (vi) If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR Sec. 164.524 and 164.526.
- (3) An enrollee of an MCO, PIHP, or PAHP (consistent with the scope of the PAHP's contracted services) has the right to be furnished health care services in accordance with Secs. 438.206 through 438.210.
- (c) Free exercise of rights. The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, or PCCM and its providers or the State agency treat the enrollee.
- (d) Compliance with other Federal and State laws. The State must ensure that each MCO, PIHP, PAHP, and PCCM complies with any other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality).

Subpart D--Quality Assessment and Performance Improvement

Sec. 438.204 Elements of State quality strategies.

At a minimum, State strategies must include the following:

- (a) The MCO and PIHP contract provisions that incorporate the standards specified in this subpart.
- (b) Procedures that—
- (1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.
- (2) Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.
- (3) Regularly monitor and evaluate the MCO and PIHP compliance with the standards.

- (c) For MCOs and PIHPs, any national performance measures and levels that may be identified and developed by CMS in consultation with States and other relevant stakeholders.
- (d) Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO and PIHP contract.
- (e) For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.
- (f) An information system that supports initial and ongoing operation and review of the State's quality strategy.
- (g) Standards, at least as stringent as those in the following sections of this subpart, for access to care, structure and operations, and quality measurement and improvement.

Sec. 438.240 Quality assessment and performance improvement program.

(a) General rules.

(1) The State must require, through its contracts, that each MCO and PIHP have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.

(2) CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by States in their contracts with MCOs and PIHPs.

(b) Basic elements of MCO and PIHP quality assessment and performance improvement programs. At a minimum, the State must require that each MCO and PIHP comply with the following requirements:

(1) Conduct performance improvement projects as described in paragraph (d) of this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

(2) Submit performance measurement data as described in paragraph (c) of this section.

(3) Have in effect mechanisms to detect both underutilization and overutilization of services.

(4) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

(c) Performance measurement. Annually each MCO and PIHP must—

(1) Measure and report to the State its performance, using standard measures required by the State including those that incorporate the requirements of Sec. 438.204(c) and Sec. 438.240(a)(2);

(2) Submit to the State, data specified by the State, that enables the State to measure the MCO's or PIHP's performance; or

(3) Perform a combination of the activities described in paragraphs (c)(1) and (c)(2) of this section.

(d) Performance improvement projects.

(1) MCOs and PIHPs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas, and that involve the following:

(i) Measurement of performance using objective quality indicators.

(ii) Implementation of system interventions to achieve improvement in quality.

(iii) Evaluation of the effectiveness of the interventions.

(iv) Planning and initiation of activities for increasing or sustaining improvement.

(2) Each MCO and PIHP must report the status and results of each project to the State as requested, including those that incorporate the requirements of Sec. 438.240(a)(2). Each performance improvement project must be completed in a reasonable time period so as to

generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

(e) Program review by the State.

(1) The State must review, at least annually, the impact and effectiveness of each MCO's and PIHP's quality assessment and performance improvement program. The review must include—

(i) The MCO's and PIHP's performance on the standard measures on which it is required to report; and

(ii) The results of each MCO's and PIHP's performance improvement projects.

(2) The State may require that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.

Subpart F--Grievance System

(Please note that not all provisions apply to Mental Health Plans per approved waiver renewal request. See contract terms to identify specific requirements of the MHPs.)

Sec. 438.400 Statutory basis and definitions.

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:

Action means-- In the case of an MCO or PIHP—

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service;

(4) The failure to provide services in a timely manner, as defined by the State;

(5) The failure of an MCO or PIHP to act within the timeframes provided in Sec. 438.408(b); or

(6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under Sec. 438.52(b)(2)(ii), to obtain services outside the network.

Appeal means a request for review of an action, as "action" is defined in this section.

Grievance means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

Sec. 438.402 General requirements.

(a) The grievance system. Each MCO and PIHP must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system.

(b) Filing requirements—

(1) Authority to file.—

- (i) An enrollee may file a grievance and an MCO or PIHP level appeal, and may request a State fair hearing.
- (ii) A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.
- (2) Timing. The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the MCO's or PIHP's notice of action. Within that timeframe—
 - (i) The enrollee or the provider may file an appeal; and
 - (ii) In a State that does not require exhaustion of MCO and PIHP level appeals, the enrollee may request a State fair hearing.
- (3) Procedures.
 - (i) The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO or the PIHP.
 - (ii) The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.

Sec. 438.404 Notice of action.

- (a) Language and format requirements. The notice must be in writing and must meet the language and format requirements of Sec. 438.10(c) and (d) to ensure ease of understanding.
- (b) Content of notice. The notice must explain the following:
 - (1) The action the MCO or PIHP or its contractor has taken or intends to take.
 - (2) The reasons for the action.
 - (3) The enrollee's or the provider's right to file an MCO or PIHP appeal.
 - (4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing.
 - (5) The procedures for exercising the rights specified in this paragraph.
 - (6) The circumstances under which expedited resolution is available and how to request it.
 - (7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.
- (c) Timing of notice. The MCO or PIHP must mail the notice within the following timeframes:
 - (1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in Secs. 431.211, 431.213, and 431.214 of this chapter.
 - (2) For denial of payment, at the time of any action affecting the claim.
 - (3) For standard service authorization decisions that deny or limit services, within the timeframe specified in Sec. 438.210(d)(1).
 - (4) If the MCO or PIHP extends the timeframe in accordance with Sec. 438.210(d)(1), it must—
 - (i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and
 - (ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
 - (5) For service authorization decisions not reached within the timeframes specified in Sec. 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.
 - (6) For expedited service authorization decisions, within the timeframes specified in Sec. 438.210(d).

Sec. 438.406 Handling of grievances and appeals.

(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

- (1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- (2) Acknowledge receipt of each grievance and appeal.
- (3) Ensure that the individuals who make decisions on grievances and appeals are individuals—
 - (i) Who were not involved in any previous level of review or decision-making; and
 - (ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.
 - (A) An appeal of a denial that is based on lack of medical necessity.
 - (B) A grievance regarding denial of expedited resolution of an appeal.
 - (C) A grievance or appeal that involves clinical issues.
- (b) Special requirements for appeals. The process for appeals must:
 - (1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.
 - (2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)
 - (3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.
 - (4) Include, as parties to the appeal—
 - (i) The enrollee and his or her representative; or
 - (ii) The legal representative of a deceased enrollee's estate.

Sec. 438.408 Resolution and notification: Grievances and appeals.

- (a) Basic rule. The MCO or PIHP must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.
- (b) Specific timeframes.—
- (1) Standard disposition of grievances. For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 days from the day the MCO or PIHP receives the grievance.
 - (2) Standard resolution of appeals. For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.
 - (3) Expedited resolution of appeals. For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.
- (c) Extension of timeframes.—
- (1) The MCO or PIHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—
 - (i) The enrollee requests the extension; or
 - (ii) The MCO or PIHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.

(2) Requirements following extension. If the MCO or PIHP extends the timeframes, it must--for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.

(d) Format of notice.—

(1) Grievances. The State must establish the method MCOs and PIHPs will use to notify an enrollee of the disposition of a grievance.

(2) Appeals.

(i) For all appeals, the MCO or PIHP must provide written notice of disposition.

(ii) For notice of an expedited resolution, the MCO or PIHP must also make reasonable efforts to provide oral notice.

(e) Content of notice of appeal resolution. The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the enrollees—

(i) The right to request a State fair hearing, and how to do so;

(ii) The right to request to receive benefits while the hearing is pending, and how to make the request; and

(iii) That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the MCO's or PIHP's action.

(f) Requirements for State fair hearings.—

(1) Availability. The State must permit the enrollee to request a State fair hearing within a reasonable time period specified by the State, but not less than 20 or in excess of 90 days from whichever of the following dates applies—

(i) If the State requires exhaustion of the MCO or PIHP level appeal procedures, from the date of the MCO's or PIHP's notice of resolution; or

(ii) If the State does not require exhaustion of the MCO or PIHP level appeal procedures and the enrollee appeals directly to the State for a fair hearing, from the date on the MCO's or PIHP's notice of action.

(2) Parties. The parties to the State fair hearing include the MCO or PIHP as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

Sec. 438.410 Expedited resolution of appeals.

(a) General rule. Each MCO and PIHP must establish and maintain an expedited review process for appeals, when the MCO or PIHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

(b) Punitive action. The MCO or PIHP must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

(c) Action following denial of a request for expedited resolution. If the MCO or PIHP denies a request for expedited resolution of an appeal, it must—

(1) Transfer the appeal to the timeframe for standard resolution in accordance with Sec. 438.408(b)(2);

(2) Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.

Sec. 438.414 Information about the grievance system to providers and subcontractors.

The MCO or PIHP must provide the information specified at Sec. 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

Sec. 438.416 Recordkeeping and reporting requirements.

The State must require MCOs and PIHPs to maintain records of grievances and appeals and must review the information as part of the State quality strategy.

Sec. 438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending.

(a) Terminology. As used in this section, "*timely*" filing means filing on or before the later of the following:

(1) Within ten days of the MCO or PIHP mailing the notice of action.

(2) The intended effective date of the MCO's or PIHP's proposed action.

(b) Continuation of benefits. The MCO or PIHP must continue the enrollee's benefits if—

(1) The enrollee or the provider files the appeal timely;

(2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(3) The services were ordered by an authorized provider;

(4) The original period covered by the original authorization has not expired; and

(5) The enrollee requests extension of benefits.

(c) Duration of continued or reinstated benefits. If, at the enrollee's request, the MCO or PIHP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

(1) The enrollee withdraws the appeal.

(2) Ten days pass after the MCO or PIHP mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.

(3) A State fair hearing Office issues a hearing decision adverse to the enrollee.

(4) The time period or service limits of a previously authorized service has been met.

(d) Enrollee responsibility for services furnished while the appeal is pending. If the final resolution of the appeal is adverse to the enrollee, that is, upholds the MCO's or PIHP's action, the MCO or PIHP may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in Sec. 431.230(b) of this chapter.

Sec. 438.424 Effectuation of reversed appeal resolutions.

(a) Services not furnished while the appeal is pending. If the MCO or PIHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO or PIHP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

(b) Services furnished while the appeal is pending. If the MCO or PIHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the PIHP or the State must pay for those services, in accordance with State policy and regulations.

Subpart H--Certifications and Program Integrity**Sec. 438.604 Data that must be certified.**

(a) Data certifications. When State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP, the State must require certification of the data as provided in Sec. 438.606. The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the State and contained in contracts, proposals, and related documents.

(b) Additional certifications. Certification is required, as provided in Sec. 438.606, for all documents specified by the State.

Sec. 438.606 Source, content, and timing of certification.

(a) Source of certification. For the data specified in Sec. 438.604, the data the MCO or PIHP submits to the State must be certified by one of the following:

(1) The MCO's or PIHP's Chief Executive Officer.

(2) The MCO's or PIHP's Chief Financial Officer.

(3) An individual who has delegated authority to sign for, and who reports directly to, the MCO's or PIHP's Chief Executive Officer or Chief Financial Officer.

(b) Content of certification. The certification must attest, based on best knowledge, information, and belief, as follows:

(1) To the accuracy, completeness and truthfulness of the data.

(2) To the accuracy, completeness and truthfulness of the documents specified by the State.

(c) Timing of certification. The MCO or PIHP must submit the certification concurrently with the certified data.

Sec. 438.610 Prohibited Affiliations with Individuals Debarred by Federal Agencies.

(a) General requirement. An MCO, PCCM, PIHP, or PAHP may not knowingly have a relationship of the type described in paragraph (b) of this section with the following:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of this section.

(b) Specific requirements. The relationships described in this paragraph are as follow:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP.

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity.

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

(c) Effect of Noncompliance. If a State finds that an MCO, PCCM, PIHP, or PAHP is not in compliance with paragraphs (a) and (b) of this section, the State:

(1) Must notify the Secretary of the noncompliance.

(2) May continue an existing agreement with the MCO, PCCM, PIHP, or PAHP unless the Secretary directs otherwise.

(3) May not renew or otherwise extend the duration of an existing agreement with the MCO, PCCM, PIHP, or PAHP unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

(d) Consultation with the Inspector General. Any action by the Secretary described in paragraphs (c)(2) or (c)(3) of this section is taken in consultation with the Inspector General.